MG11T

HAMPSHIRE CONSTABULARY

RESTRICTED – For Police and Prosecution Only

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

URN //

Statement of : STEVEN ALEC WATTS

Age if under 18: *(if over 18 insert 'over18')* **Occupation:** Police Officer

This statement (consisting of 11 page(s) each signed by me) is true to the best of my knowledge and belief and I make it knowing that, if it is tendered in evidence, I shall be liable to prosecution if I have wilfully stated in it anything which I know to be false or do not believe to be true.

Signature: Code A **Date:** 30TH September 2004.

Tick if witness evidence is visually recorded ☐ *(supply witness details on rear)*

I am Detective Chief Superintendent Steven WATTS, Head of Hampshire Constabulary Criminal Investigation Department and am the senior investigating officer in respect of a police investigation named 'Operation ROCHESTER', an investigation into the circumstances surrounding of death of 88 patients occurring principally during the late 1990's at Gosport War Memorial Hospital, Hampshire.

This investigation followed allegations that during the 1990's elderly patients at Gosport War Memorial Hospital received sub optimal or sub- standard care, in particular with regard to inappropriate drug regimes, and as a result their deaths were hastened.

The strategic objective of the investigation is to establish the circumstances surrounding the deaths of those patients to gather evidence and with the Crown Prosecution Service (CPS), to establish whether there is any evidence that an individual has criminal culpability in respect of the deaths.

During the investigation, a number of clinical experts have been consulted.

Signed : Code A Signature witnessed by : _____

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URN //

Statement of : STEVEN ALEC WATTS

On the 9th November 2000 Professor Brian LIVESLY reported on the death of a patient, Mrs. RICHARDS.

On the 12th February 2001 Professor FORD reported in respect of the deaths of five patients RICHARDS, CUNNINGHAM, WILKIE, WILSON and PAGE

On the 18th October 2001 Professor MUNDY reported on the deaths of patients CUNNINGHAM, WILKIE, WILSON and PAGE.

The aforementioned reports have all previously been made available to the General Medical Council.

Between October 2001 and May 2002 the Commission for Health Improvement interviewed 59 hospital staff in respect of the deaths, and concluded that, "a number of factors contributed to a failure of trust systems to ensure good quality patient care".

Between September 2002 and May 2004 the cases of 88 patients including those named above, at the Gosport War Memorial Hospital were fully reviewed at my request by a team of five experts in the disciplines of toxicology, general medicine, palliative care, geriatrics and nursing.

Code A

Signed : S.A.WATTS. Signature witnessed by : _____

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(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

URN //

Statement of : STEVEN ALEC WATTS

All the cases examined were elderly patients (79 to 99yrs of age) theirs deaths occurring at Gosport War Memorial hospital between January 1996 and November 1999. A common denominator in respect of the patient care is that many were administered Opiates authorized by Dr Jane BARTON prior to death.

The expert team was commissioned to independently and then collectively assess the patient care afforded to the 88 patients concerned, examining in detail patient records, and to attribute a 'score' according to their findings against agreed criteria. A further group of cases were included in this review following a report by Dr BAKER, commissioned by the Chief Medical Officer. That report is confidential to the CMO and may not be discussed further without his agreement.

The team of experts has 'scored' the cases as follows.

Category one- There were no concerns in respect of these cases upon the basis that 'optimal care' had been delivered to patients prior to their death.

Category two - Specific concerns that these patients had received 'sub optimal' care.

These cases are currently undergoing a separate quality assurance process by a medico legal expert to confirm their 'rating'. Nineteen of these cases that have been 'confirmed', have been formally released from police investigation and handed to the General Medical Council for their consideration. A number of cases

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WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

URN //

Statement of : STEVEN ALEC WATTS

have been identified as appropriate for further scrutiny to confirm grading, and the quality assurance process in respect of the remaining cases will be complete by early October 2004.

Category three Patient care in respect of these cases has been assessed as 'negligent, that is to say outside the bounds of acceptable clinical practice'.

The police investigation into these cases is, therefore continuing.

The five experts commenced their analysis of patient records in February 2003. It is anticipated that their work will be finalized in October 2004 as will the quality assurance process by the medico legal expert.

As part of the ongoing investigative strategy, since May 2004 a further tier of medical experts, in Geriatrics and Palliative Care have been instructed to provide an evidential assessment of the patient care in respect of in the 'Category three' cases. The work of these experts is ongoing and is not likely to have been fully completed until the end of 2004 when if appropriate papers will be reviewed and considered by the Crown Prosecution Service.

At the same time, the police investigation team continue to take statements from healthcare professionals, liaise with key stakeholders, provide a family liaison service, formulate and deliver strategies in respect of witness/suspect interviews, deal with exhibits, complete disclosure schedules, and populate the major crime

Code A

Signed : S.A.WATTS. Signature witnessed by : _____

MG11T

HAMPSHIRE CONSTABULARY

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(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

URN //

Statement of : STEVEN ALEC WATTS

investigation 'Holmes' system a national police IT application used to record and analyze information relating to serious/complex police investigations.

To date 330 witness statements have been taken and 349 officer's reports created. 1243 'Actions' have been raised, each representing a specific piece of work to be completed arising from an issue raised within a document or other information source. This is a major investigation which has required a considerable input and commitment of human and financial resources on the part of the Hampshire Constabulary.

Whilst investigations will be fully completed in respect of all of the 'Category three' cases, a small number of sample cases have been selected and work is being prioritized around those with a view to forwarding papers to the CPS as soon as possible by way of expedition. Timescales for this action are clearly dependant upon completion of expert review of these cases and completion of the witness statements of key healthcare professionals. This is necessarily a lengthy process,

In the event that there is considered a sufficiency of evidence to forward papers to the CPS, it is estimated that this will be completed on an incremental basis. The first cases arriving in December 2004 or early 2005.

I understand that the General Medical Council has a duty to provide the fullest possible evidence for consideration by the Interim Order Committee. I am also aware that they also have a duty to disclose the same information in its entirety to those appearing before the committee.

Signed : Code A

Signature witnessed by : _____

MG11T

HAMPSHIRE CONSTABULARY

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URN //

Statement of : STEVEN ALEC WATTS

In my view, this situation has the potential to compromise the integrity and effectiveness of any interviews held under caution with health care professionals involved in this enquiry.

Police investigative interviewing operates from seven basic principles, which are laid out in Home Office Circular 22/1992. The first of these being that

"Officers seek to obtain accurate and reliable information from suspects, witnesses or victims in order to discover the truth about matters under police investigation."

Investigative interviewing should be approached with an open mind. Information obtained from a person who is being interviewed should always be tested against what the interviewing officer already knows or what can be reasonably established.

This investigation is currently following various lines of enquiry seeking to establish whether or not any criminal offence has been committed. At present it has not been established that this is the case or in fact whether or not any person is potentially culpable. Once an individual has been identified then decisions have to be made as to what they need to be interviewed about and what information it is proper to disclose to that person prior to their being interviewed.

Decisions as to what the police have to disclose prior to interviews under caution are covered by various aspects of case law, in particular R v Code A 1997). The court commented in this case that the police have

Signed : Code A Signature witnessed by : _____

MG11T

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URN //

Statement of : STEVEN ALEC WATTS

The Police have an over riding responsibility to conduct an effective and ethical investigation and a have a legal and moral duty to be scrupulously fair to suspects. In addition the police carry an additional responsibility to representing the interests of the victims of crime and society in general. Therefore to provide a guilty suspect with the ability to fabricate a defence around police evidence does not serve those wider interests.

As the senior investigating officer I acknowledge the primacy of the public protection issues surrounding this case.

I understand that there is a voluntary agreement in place between Dr BARTON and the Fareham and Gosport Healthcare Trust of November 2002, the following is a quotation from an e mail message to the investigation from the trust in respect of that matter.

'Dr BARTON has undertaken not to prescribe benzodiazepines or opiate analgesics from the 1st October 2002. All patients requiring ongoing therapy with such drugs are being transferred to other partners within the practice so that their care would not be compromised.

Dr Code A ***will not accept any house visits if there is a possible need for such drugs to be prescribed. Problems may arise with her work for Health-call as a prescription may be required for a 14 day supply of benzodiazepines for bereavement.***

Dr BARTON also agreed to follow up all previous prescriptions for high quantities using the practice computer system and the patient's notes.

Signed : Code A

Signature witnessed by : _____

MG11T

HAMPSHIRE CONSTABULARY

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URN //

Statement of : STEVEN ALEC WATTS

During a 13month periods from April 2003 Dr Code A ***had written a total of 20 prescriptions all for 2mg diazepam to relatives of deceased and had not prescribed any diamorphine, morphine or other controlled drug.'***

I have been asked by the General Medical Council to provide an update as to the current position in respect of four cases previously considered by interim order committee during September 2002.

Arthur CUNNINGHAM - this has been assessed as a category three case and is being investigated accordingly.

Robert WILSON - again a category three case.

Gladys RICHARDS.- Assessed as a category two case by the clinical team, this assessment has been queried through the quality assurance process and is to be subject of further review by the clinical experts in early October 2004.

Alice WILKIE. – No further police action to be taken in respect of this investigation. The medical records available are not sufficient to enable an assessment.

In closing it is appropriate for me to emphasize some key points;

1. There is no admissible evidence at this time of criminal culpability in respect of any individual.
2. The information adduced by the investigation thus far, and the findings of the experts lead me to have concerns that are such that, in my judgment the continuing investigation and the high level of resources being applied to it are justified.

Signed: Code A Signature witnessed by : _____

MG11T

HAMPSHIRE CONSTABULARY

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WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

URN //

Statement of : STEVEN ALEC WATTS

Code A

Signed

Signature witnessed by : _____

FORMAT OF FILE CONTENTS

1. DOCUMENT LISTING THE CONTENTS OF THREE BOXES DELIVERED TO G.M.C 10 09 2004

2 REVIEW OF EXPERTS

A.
B.
C.
D.

Code A

3. POLICE OFFICER'S REPORT

4. CASE REVIEWS BY

Code A

CONTENTS OF BOXES TO G.M.C. 10 09 2004

REF.	NAME	FILE CONTENT
BJC/1A	VICTOR ABBATT	COPY OF MICROFILM PAPERS
BJC/2	DENNIS AMEY	COPY OF MICROFILM PAPERS
BJC/6A	CHARLES BATTY	COPIES OF TWO SETS OF MICROFILM PAPERS
BJC/6B	DENNIS BRICKWOOD	COPY OF PAPER RECORDS
BJC/9	SYDNEY CHIVERS	COPIES OF TWO SETS OF PAPER RECORDS
BJC/17	CYRIL DICKS	COPIES OF TWO SETS OF PAPER RECORDS AND COPY OF MICROFILM PAPERS
BJC/23	CHARLES HALL	COPY OF PAPER RECORDS AND COPIES OF TWO SETS OF MICROFILM RECORDS
BJC/31	CATHERINE LEE	COPIES OF TWO SETS OF PAPER RECORDS
BJC/7	STANLEY CARBY	COPIES OF TWO SETS OF PAPER RECORDS
BLC/12	WALTER CLISSOLD	COPY OF PAPER RECORDS

BJC/22 & JR/1	HARRY HADLEY	COPIES OF TWO SETS OF PAPER RECORDS AND A COPY OF MICROFILM PAPERS
BJC/26	ALAN HOBDAY	COPY OF PAPER RECORDS AND A COPY OF MICROFILM PAPERS
BJC/35	EVA PAGE	COPY OF PAPER RECORDS
BJC/36	GWENDOLINE PARR	COPY OF PAPER RECORDS
BJC/37	EDNA PURNELL	COPIES OF TWO SETS OF PAPER RECORDS AND A COPY OF MICROFILM PAPERS
BJC/38	MARGARET QUEREE	COPY OF PAPER RECORDS AND COPIES OF TWO MICROFILM PAPERS
BJC/40	VIOLET REEVE	COPY OF PAPER RECORDS AND A COPY OF MICROFILM PAPERS
BJC/42	JAMES RIPLEY	COPIES OF TWO SETS OF PAPER RECORDS
BJC/47	DAPHNE TAYLOR	COPY OF MCROFILM PAPERS

1 495 005

HAMPSHIRE CONSTABULARY

HARRY HADLEY

HARRY HADLEY

Harry Hadley

Date of Birth: 1 Code A Age: **85**
Date of admission to GWMH: **5th October 1999**
Date and time of Death: **06.50 hours on 10th October 1999**
Cause of Death:
Post Mortem:
Length of Stay: **5 days**

Mr Hadley's past medical history:-
CA bladder – diagnosed July 1999

Mr Hadley was a widower and lived alone in a flat. He had a daughter who was his main carer and a son. She became unable to cope any longer.
Mr Hadley was admitted to Gosport War Memorial Hospital on 5th October 1999. Mr Hadley had a long term catheter in situ, had to wear compression stockings for lymphoedema. Mr Hadley was immobile and required the help of two nurses plus aides. It was noted that Mr Hadley's genitalia was quite swollen and that his sacrum was red and grazed and dressed with granuflex and looked likely to breakdown.

On admission an assessment sheet was completed noting that Mr Hadley appears fully aware of his condition stated that he is dying but wishes it was sooner rather than later. It noted that he wore glasses for long distances and reading and that he had a small appetite and had difficulty with chewy food.
Care plans were commenced on 5th October 1999 for hygiene, catheter care – penis oedematous and scrotum swollen and skin excoriated, pain in pressure area – broken area x 2 to left buttock, cleft of buttock excoriated and heels discoloured and at risk, constipation, reduced appetite and help to settle at night.
A nutritional screening tool was also completed on 5th October noting a score of 17.
A Waterlow score of 15 was recorded on 5th October, pressure sore documentation noted that Mr Hadley was nursed on a Pegasus mattress and that dressing of duoderm was applied to buttocks.
A Barthel ADL index also dated 5th October scored 3.
A handling profile on 5th October noted that Mr Hadley was able to communicate effectively, that he had pain in the lower half of his body when turned, that he had 2 broken areas on his left buttock and that the cleft of his buttock was excoriated. It also noted that Mr Hadley needed the help of two nurses and nursed on a Pegasus airbed.

5th October 1999

Clinical notes state CA bladder with metasteses. Has been in a little discomfort. For TLC. Family concerned re: change in medication.
Summary states admitted from C3 Royal Haslar Hospital admitted there on 22th September 1999 with acute retention of urine.
15.00 hours seen by Dr Code A MST discontinued for diazepam 5mgs.
19.30 hours relatives expressed concern over medication and analgesia control. Dr Code A to rewrite MST.

6th October 1999

Clinical notes state that Mr Code A is fine to have MST.

7th October 1999

Summary states seen by Dr Code A commenced on syringe driver 60 mgs diamorphine 100mg cyclonize happy for that to be increased. Daughter visited and explained about syringe driver and poor prognosis.

8th October 1999

Summary notes seen by Dr Code A second syringe driver commenced.

9th October 1999

Clinical notes state agitated, restless, twitchy ++, seems unable to speak yet looking around. Rattly chest.
Was on 20mg MST bd changed to syringe driver from past 48 hours with 60mg diamorphine for past 24 hours.
Wonder if agitation is due to rapid increase in diamorphine or hyoscine. Try reducing diamorphine back to 30 mgs in 24 hours (equiv to 50mg MST bd).
PM – getting chesty and distressed increase rate from 60mm/day to 99 and then change to 60mg diamorphine over 24 hours when it runs out.
Hyoscine can be given 4-5 hourly.
Summary state seen by Dr Code A diamorphine reduced to 30 mgs very chesty.
21.30 hours distressed seen by Dr Code A syringe driver increased from **60mm to 99mm over 24 hours**. When infusion complete resume to 60mm with 60mg diamorphine.

10th October 1999

Patient confirmed dead at 06.50 hours by S/N Code A

Code A

BJC/22
HARRY HADLEY
85

Metastatic carcinoma of bladder. They originally tried to help with the agitation without increasing the opiate but had to re-introduce MST. The starting dose of diamorphine looks too high but they increased it the next day, tried to reduce it and found that they had to increase it again. The underlying illness was terminal but the control of agitation and distress was handled poorly.

PL grading B2

Code A

DOCUMENT RECORD PRINT

Officer's Report

Number: R11B

TO:
STN/DEPT:

REF:

FROM: DC 2479 YATES
STN/DEPT: MCIT W

REF:
TEL/EXT:

SUBJECT:

DATE: 02/12/2002

Sir

Re: ACTION 200

I have spoken to Mr and Mrs Code A Mrs Code A had reported that her father had been admitted to the Gosport War Memorial Hospital in 1999 and died shortly afterwards. Neither person wish to make any complaint or allegation but have forwarded this information in case it assists the police enquiry. The circumstances of her fathers death are as follows:

Harry Leman HANDLEY (b. Code A) of Code A ad been suffering with terminal prostate cancer for several years. His wife died in 1998 and this marked a noticeable deterioration in his health.

In October 1999 Mr HANDLEY was admitted to RNH Haslar with prostate problems. On 5th October 1999 (05/10/1999) he was transferred to the Gosport War Memorial Hospital, Sultan Ward. Mr HANDLEY knew that he was terminally ill and was refusing treatment on occasions. He had also lost his appetite and was not eating correctly.

When first at the Gosport War Memorial Hospital Mr HANDLEY was sitting up and talking but his health soon deteriorated and he was placed in a room on his own. He was prescribed Diamorphine for the pain which was first administered orally, then by injection and finally by the use of a syringe driver. Mr Code A was asleep all the time that he was on Diamorphine.

On 10th October 1999 (10/10/1999) Mr HANDLEY died, the cause of death was recorded as Carcinoma of the bladder with Metastases and was certified by Dr PANNALL who was his GP at the Stoke Road Surgery in Gosport .

Mr HANDLEY was cremated.

Mr and Mrs Code A ave been informed that Operation Rochester is an ongoing police investigation and they were given a contact number.

C S YATES

DOCUMENT RECORD PRINT

Officer's Report

Number: R7AY

TO:
STN/DEPT:

REF:

FROM: DETECTIVE CONSTABLE 424 ROBINSON
STN/DEPT: MCD E

REF:
TEL/EXT:

SUBJECT:

DATE: 01/12/2003

I visited Sandra HOWELL and her husband at their home address at 1300 hrs on Friday 28th November 2003 (28/11/2003) in accordance with the policy log. I went through the concerns and details given by Mrs HOWELL as noted in R11B.

Her additional observations are as follows:

If her father required palliative care then why was he not sent to a hospice?

That on the Saturday prior to his death he was fully compos mentis. He died at 0745 on the Sunday (10/10/1999).

That during the time he was being prescribed pain relief he wasn't asleep but sedated. He was unable to speak but was awake and aware.

Mr and Mrs HOWELL would be happy to be notified by letter as long as it contained enough detail and was written in 'lay terms'.

I provided Mrs HOWELL with a set of her father's medical records.

Expert Review

Harry Hadley

No. BJC/22

Date of Birth: Code A

Date of Death: 10 October 1999

Mr Hadley was admitted to Gosport War Memorial Hospital on 5 October 1999. At the time he was fully aware of his condition having been diagnosed with carcinoma of the bladder in July 1999. Mr Hadley was immobile and required the assistance of nurses plus aides.

Mr Hadley died on 10th October 1999. In the last five days before his death Mr Hadley was inexpertly treated with opioid analgesics although this did not in any way substantively alter the prognosis.

ALAN HOBDAY

ALAN HOBDAY

Alan Hobday

Date of Birth: Code A Age: **75**
Date of admission to GWMH: **24th July 1998**
Date and time of Death: **22.45 hours on 11th September 1998**
Cause of Death:
Post Mortem:
Length of Stay: **50 days**

Mr Hobday's past medical history:-
1990 – TURProstatectomy

Mr Hobday lived with his wife in a bungalow. They had a son and daughter and very supportive family. Mr Hobday was a very well man prior to his collapse. He was allergic to penicillin.
Mr Hobday collapsed while out eating and was taken by ambulance to St Mary's Hospital and diagnosed with suffering a left CVA and right hemiplegia. Mr Hobday was admitted to Gosport War Memorial Hospital on 24th July 1998.

On admission care plans commenced on 25th July 1998 for sleep, catheter, shoulder pain, dysphagia, elimination, hygiene and communication.
A lifting/handling risk calculator was taken on 24th July 1998 scoring 23. So a handling profile was completed on 25th July 1998 noting that Mr Hobday needed the assistance of 2 nurses and a hoist, that his skin was intact and that he was to be nursed on a Pegasus biwave plus mattress.
A nutritional assessment plan was completed on 4th September 1998 with a score of 12 recorded.
An assessment sheet was completed noting that Mr Hobday was unable to communicate,
A Waterlow score of 25 was recorded on 24th July 1998.
A Barthel ADL index wad recorded weekly starting on 24th July 1998 scoring 0 and the last one recorded on 9th September 1998 also scoring 0.

24th July 1998

Clinical notes admitted to Daedulus ward. Barthel 0 needs all help with ADL. In view of poor prognosis please make comfortable. **Happy for nursing staff to confirm death.**

25th July 1998

Contact record – wife and daughter seen aware of condition and prognosis and recovery will be limited.

HAMPSHIRE CONSTABULARY

30th July 1998

Clinical notes state catheterised. Pulling out S/C fluids does not want NG feed. Prognosis poor. Wife and daughter seen they feel he has settled and improved from a week ago. Poor swallow, aspiration and possible chest infection. Diamorphine/haloperidol PM if distressed.

31st July 1998

Clinical notes seen by SLT continue with puree diet and thickened fluids.

3rd August 1998

Clinical notes remains poorly.

6th August 1998

Contact record – found on floor in lounge. No injury apparent. Accident form completed.

12th August 1998

Clinical notes has made some progress. Family seem realistic about future.
Contact record – discussion with wife and daughter definite improvement made with physical condition. Discussed future care they seem realistic about his capabilities.

16th August 1998

Contact record – found on floor in day room. Put back to bed. Accident form completed. Wife informed.

17th August 1998

Clinical notes very agitated at times. Suggest S/C haloperidol.

20th August 1998

Clinical notes seen by dietician continue on puree diet and thickened fluids. Slow progress can push himself out of chair.

22nd August 1998

Contact record – found on floor in day room. No apparent injury. Hoisted into bed. Accident form completed.

7th September 1998

Contact record – twitching (facial) complaining of not feeling well. Dr Barton and wife informed.
Seen by Dr Code A commence **diamorphine 20mgs via syringe driver**. Wife and daughter seem to understand may deteriorate.

9th September 1998

Contact record – **diamorphine increased 40mgs** became very restless and appeared in discomfort.

10th September 1998

Clinical notes extended stroke on 6th September 1998 with facial seizures affecting right side of face. Now on syringe driver secretions +++ but seems comfortable. He's dying, family aware.
Contact record – seen by Dr Lord coughing and bubbling chest. Move to continuing care bed.

11th September 1998

Contact record – syringe driver renewed at 9.45 diamorphine 40mgs.
Clinical notes condition deteriorated rapidly.
Pronounced dead at 22.45 hours by S/N Code A relatives present.

Code A

BJC/26
ALAN HOBDAY
75

He had a severe stroke followed by an extension of the stroke. There were feeding difficulties but he made some progress. On 7/9/98 he developed focal seizures and increased pain in his arm. Diamorphine via syringe driver started and the dose needed increasing because of ongoing discomfort. I would have started at 10mg rather than 20mg over 24 hours (hence grade 2) but otherwise the analgesia was appropriate and well controlled. Cause of death was the stroke.

PL grading A2

Code A

DOCUMENT RECORD PRINT

Officer's Report

Number: R7BB

TO:
STN/DEPT:

REF:

FROM: DETECTIVE CONSTABLE 424 ROBINSON
STN/DEPT: MCD E

REF:
TEL/EXT:

SUBJECT:

DATE: 16/12/2003

I visited Michael HOBDAY at 1600 hrs on Tuesday 16th December 2003 (16/12/2003) in accordance with the policy log.

I introduced myself and explained my role as FLO, provided Mr HOBDAY with a set of medical records in relation to his father, Alan William HOBDAY Code A - 11/09/1998.

I outlined his concerns as given in A194 and M24. He further elaborated stating that his father suffered a stroke in July 1998 and was admitted to the Queen Alexandra Hospital where he began to recover and was transferred to the GWMH where he continued to improve.

On 4th September 1998 (04/09/1998) the family were told that Mr HOBDAY had suffered a further stroke and that it was unlikely that he would survive. From that point he was placed on a syringe driver and he died on 11/09/1998.

Mr HOBDAY is acting as spokesman for the family and his mother has made some handwritten notes relating to her husbands death (attached).

Mr HOBDAY is happy to be notified by way of letter, with the opportunity to be able to raise any queries at a later date.

Expert Review

Alan Hobday

No. BJC/26

Date of Birth: Code A

Date of Death: 11 September 1998

Mr Hobday had suffered a stroke in July 1998 and was admitted to hospital. He was transferred to Gosport War Memorial Hospital on 24 July 1998 for further rehabilitation.[AH1]

On the clinical notes it would appear that he extended his stroke on 6 September 1998 and thereafter developed focal seizures with increased pain in his arm.

Diamorphine was started via a syringe driver and Mr Hobday died on 11 September 1998.

The expert report confirmed that although higher doses of opiates were used than may have been necessary, Mr Hobday's cause of death was due to his stroke.

EVA PAGE

EVA PAGE

Eva Page

Date of Birth: Code A Age: **88**
Date of admission to GWMH: **27th February 1998**
Date and time of Death: **21.30 hours on 3rd March 1998**
Cause of Death:
Post Mortem: **Cremation**
Length of Stay: **5 days**

Mrs Page's past medical history:-

Confusion
1995 - Atrial fibrillation
CCF
1995 – LVF
1997 – TIA
1995 – Digoxin Toxicity

Mrs Page was widowed and lived at Chesterholm Lodge Residential Home. She had a son.
Mrs Page was admitted to Queen Alexander Hospital as an emergency suffering with anorexia, decreasing mobility, sleeping a lot and becoming dehydrated. She was transferred to Gosport War Memorial Hospital on 27th February 1998 for palliative care.

On admission a Barthel ADL index score was recorded of 2. Care plans commenced on the day of admission for settle at night, constipation, catheter care and personal hygiene.
An handling profile which noted Mrs Page can make her wishes known, she had pain on movement, dry paper thin skin, to be nursed on Pegasus biwave mattress, she had a catheter insitu for retention of urine and needs help of 2 nurses and a hoist was completed on 28th February 1999. A Waterlow score of 27 recorded also on 28th February 1999.

27th February 1999

Admitted from Queen Alexander Hospital for palliative care. It was noted that Mrs Page was withdrawn and anxious. That she would call out frequently and needed reassurance. Also noted was that Mrs Page was on a normal diet and fluids was incontinent of faeces had a catheter for retention of urine and needed help with all hygiene needs.
The transfer form noted that Mrs Page has bio? to red sacrum, an old facial wound from 15th February 1998 after fall (scabs on nose) and swelling inner left eye.

Summary – admitted from Charles Ward for palliative care.
Clinical notes – opiates commenced. **Happy for nursing staff to confirm death.**

28th February 1999

Summary – very distressed, calling for help and saying she is afraid.
Oramorph 2.5mgs given with no relief. Thioridazine given with no effect
Clinical notes – jerks a lot agitated. Not in pain.

2nd March 1999

Summary – commenced fentanyl 25mgs this am. Very distressed. Seen by Dr Barton to have diamorphine 5mgs IM given at 8.10. Seen by Dr Lord diamorphine 5mgs IM given for syringe driver with diamorphine.
Clinical notes – no improvement. Quieter PM S/C diamorphine. Fentanyl patch started today.
Agitated and calling out even when staff present.
Ct fentanyl patches. Son seen concerned about deterioration today. Explained agitation and drowsiness was probably due in part to diamorphine accepts mother is dying and agrees continue present plan.

3rd March 1999

Summary – rapid deterioration this AM. Neck and left side rigid. Syringe driver commenced at 10.50 with diamorophine 20mgs and midazolan 20mgs.
Son stayed all day aware of poor prognosis.
Condition deteriorated died 21.30 for cremation.
Clinical notes – Died peacefully verified by SN Dorrington. Son informed for cremation.

Code A

BJC/35
EVA PAGE
88

Carcinoma of lung. Described as distressed and anxious. The care and use of analgesia seems reasonable although they flirted with fentanyl for a short while and used intramuscular injections. Cause of death natural. Care being graded as sub-optimal is perhaps a little picky but relates to the changes in opioid and method of administration rather than the doses used.

PL grading A2

Code A

DOCUMENT RECORD PRINT

Officer's Report

Number: R7DB

TO: REF:
STN/DEPT:

FROM: DETECTIVE CONSTABLE 424 ROBINSON REF:
STN/DEPT: OPERATION ROCHESTER TEL/EXT:

SUBJECT: DATE: *05/05/2004*

At 1630 hrs on Wednesday 26th November 03 (26/11/2003) I visited Mr Bernard PAGE at his home address in relation to his mother, Eva Isobel PAGE . The visit was in accordance with the policy log. I outlined Mr PAGES concerns as per document 317.

Mr PAGE agreed its content and went on to give further concerns as per his statement made to Supt. CLACKER , these being; the cause of death given on his mothers death certificate was not indicated in the medical notes.

His mothers normal daily medication was suddenly stopped without reason and opiates commenced until his mother died. Mr PAGE notes that in his mothers medical records between 25/02/1998 - 27/02/1998 is an entry 'all other drugs stopped by Dr LORD ', he asks "who wrote this" and why were his mothers heart tablets stopped.

Why were opiates used when the notes do not say his mother was in pain.

The dispensing of certain drugs should only have been used specifically by a consultant specialist and been under their supervision.

Mr PAGE has concerns over the record keeping in relation to the prescribing and administering of drugs and why his mother was given so many types of medication.

Mr PAGE will forward notes made by his daughter Samantha .

He wishes to be notified by letter with a meeting to follow if required.

Expert Review

Eva Page

No. BJC/35

Date of Birth: Code A

Date of Death: 3 March 1998

Mrs Page was transferred to Gosport War Memorial Hospital on 27 February 1998 for palliative care having been treated at Queen Alexander Hospital as an emergency suffering with anorexia, decreasing mobility and dehydration.

On admission to Gosport War Memorial it was apparent that Mrs Page was dying of carcinoma of the lung. She was confused and agitated to begin with and a trial of tranquillisers did not produce any improvement. She was treated with Diamorphine and a Fentanyl patch mainly for sedation although the expert questioned whether this was appropriate in view of the lack of pain complained of. The experts agree that the cause of death was natural.

HAMPSHIRE CONSTABULARY

GWENDOLINE PARR

GWENDOLINE PARR

Gwendoline Parr

Date of Birth: Code A Age: **87**
Date of admission to GWMH: **31st December 1998**
Date and time of Death: **13.10 hours on 29th January 1999**
Cause of Death:
Post Mortem:
Length of Stay: **30 days**

Mrs Parr's past medical history:-

Dementia.
June 1991 – Heart block - pacemaker
Cholecystectomy
Appendicetomy
Basal cell carcinoma left cheek
1998 – Fracture neck of femur – dynamic hip screw
1998 – Repair umbilical hernia
Insulin dependent diabetic (diet controlled)

Mrs Parr lived alone and had a daughter and a son. Her daughter was her main carer [redacted] Mrs Parr was admitted to Gosport War Memorial Hospital on 31st December 1998 for gentle rehabilitation after being admitted to Haslar following a fall where she sustained a fracture neck of femur and underwent surgery for dynamic hip screw on 14th December 1998. During her stay at Haslar Mrs Code A developed acute abdominal pain and on 24th December 1998 underwent an umbilical hernia repair.

On admission to Gosport War Memorial Hospital care plans commenced for hygiene, settle at night, catheter care, constipation.
A lifting/handling risk calculator was completed on 31st December 1998 and 17th January 1999 both scoring 10. A handling profile was completed on 1st January 1999 noting that Mrs Parr needed the help of 2 nurses and a hoist, she had dry skin but intact and was to be nursed on a biwave mattress.
A mouth assessment form was completed.
A Barthel ADL index was completed weekly from 31st December 1998 to 24th January 1999 ranging from 2 at the start and then 1 at the end.
A weekly Waterlow score was taken from 31st December 1998 to 11th January 1999 scoring from 25 to 32.

HAMPSHIRE CONSTABULARY

31st December 1998

Admitted To Gosport War Memorial Hospital from Haslar following fall on 11th December 1998 and dynamic hip screw surgery on 14th December 1998. Mrs Parr developed acute abdominal pain on 24th December 1998 and later the same day underwent an umbilical hernia repair. Mrs Parr also had been catheterised. She was admitted for gentle rehabilitation. Transfer letter noted that Mrs Parr needed help with personal care, encouragement to mobilise and her skin was in tact.

Clinical notes – for gentle rehabilitation probably needs long term care either at Dryad Ward or Nursing Home. Left buttock ulcer.

4th January 1999

Summary – right leg remains externally rotated and shortened. Seen by Dr Barton. X-rays taken.

5th January 1999

Summary – seen by Dr Lord to have left knee X-rayed.

6th January 1999

Summary – found sitting on floor in lounge at 21.30 no injuries, not distressed.

18th January 1999

Summary – grand-daughter aware of poor prognosis. Deterioration. Frusemide given and 850 mls urine passed.

23rd January 1999

Summary – general deterioration. Oramorph 5mgs given at 15.00 with little effect. [redacted] Family will try and bring Margaret in to see Mrs Parr.

24th January 1999

Summary – remains poorly.

25th January 1999

Summary – syringe driver commenced 19.45 hours diamorphine 20mgs. Fentanyl commenced at 8.40 25mgs removed at 19.00.

27th January 1999

Summary – condition remains ill and deteriorating. Comfortable at present. Dose in syringe driver. 21.35 syringe driver reprimed with 20mgs diamorphine.

28th January 1999

Summary – syringe driver recharged 20.20 diamorphine 20mgs.

29th January 1999

Remains very poorly. Happy for nursing staff to confirm death.

Summary – died peacefully at 13.10 hours. Verified by SN Shaw and Sister Hamblin.

Code A

BJC/36
GWENDOLINE PARR
86

Repaired fractured neck of femur and umbilical hernia repair. Past history of dementia. Tried thioridazine for agitation but then used low dose opiates. Medication for heart failure was initially dropped and then increased although the reasons for this were not clear.

PL grading A2

Code A

DOCUMENT RECORD PRINT

Officer's Report

Number: R11C

TO:
STN/DEPT:

REF:

FROM: DC Code A
STN/DEPT: MCIT W

REF:
TEL/EXT:

SUBJECT:

DATE: 03/12/2002

Sir

RE: ACTION 198

I have spoken to Mr Colin PARR of Code A who had contacted the police after the media coverage of the Gosport War Memorial Hospital.

Mr PARR states that his mother, Gwendolynne Margaret PARR Code A of Code A Code A was admitted to the Royal Navy Hospital Haslar having sustained a broken hip during a fall at her home during the middle of December 1998. Mrs PARR underwent two operations the second being on Christmas Day that year. She was then transferred to the Gosport War Memorial Hospital.

Mr PARR and his family visited his mother daily at the Gosport War Memorial Hospital and stated that she was very chirpy and stated that she would soon be walking and going home. Towards the end of January 1999 staff at the hospital informed Mr Code A hat his mother had contracted a urinary infection and it was for this reason that she had been prescribed Diamorphine which was being administered through a syringe driver.

Mrs PARR's health seemed to deteriorate immediately and from the time that she was initially placed on Diamorphine she was asleep or unconscious. Within three days she died. The cause of death was given as Bronchial Pneumonia and the death certificate signed by Dr Jane BARTON.

Mrs PARR was buried at Anns Hill Cemetery, Gosport. Her GP was from the Bury Road Surgery.

Mr PARR has been told that this is an ongoing police investigation and has also been given a contact number for Operation Rochester.

C S YATES

Expert Review

Gwendoline Parr

No. BJC/36

Date of Birth: Code A

Date of Death: 29 January 1999

Mrs Parr had been admitted to the Royal Haslar Hospital in December 1998 following a fall where she sustained a fractured neck of femur. She underwent surgery for a dynamic hip screw on 14 December 1998. During her stay at the Royal Haslar Mrs Parr developed acute abdominal pain and underwent umbilical hernia repair on 24 December 1998. She was admitted to Gosport War Memorial Hospital on 31 December 1998 for rehabilitation.

The family note in the officer's report that they visited Mrs Parr daily at the Hospital and stated that "she was very chirpy and stated that she would soon be walking and going home".

Mrs Parr was noted to have deteriorated by 23 January 1999 and was commenced on Oramorph and thereafter remained poorly.

Mrs Parr died on 29 January 1999.

Dr Naysmith notes that Mrs Parr was deteriorating before the opioids were started but that the first dose of Diamorphine given would have been high even for a lady with normal renal function. This contrasted with Dr Ferner who records the treatment as being optimal with the drugs being given in "proportional doses".

Code A

HAMPSHIRE CONSTABULARY

EDNA PURNELL

HAMPSHIRE CONSTABULARY

Code A

Edna Purnell

Date of Birth: Code A Age: **90**
Date of admission to GWMH: **11th November 1998**
Date and time of Death: **11.30 hours on 3rd December 1998**
Cause of Death:
Post Mortem:
Length of Stay: **23 days**

Mrs Purnell's past medical history:-

Dementia
TIA
Vaginal wall prolapse

Mrs Purnell lived at Addenbrooke Residential Home. She had a son. Mrs Purnell was admitted to Royal Haslar Hospital after sustaining a fracture neck of femur. She underwent surgery on 26th October 1998 of a dynamic hip screw and was then admitted to Gosport War Memorial Hospital on 11th November 1998 for rehabilitation. On admission it was noted that Mrs Purnell had problem dependant oedema affecting her lower limbs and left upper limb. She was also suffering from bronchopneumonia, severe dementia and had been catheterised.

On admission care plans commenced for hygiene, confusion, urine and bowel incontinence, settle at night, graze on right elbow and both heels have pressure sores.
A handling profile was completed on admission noting that Mrs Purnell was slow to communicate, was in pain, had dry papery and broken skin, was to be nursed on a Pegasus air mattress, had a catheter in situ and needed the help with transfers using a hoist.
A mouth assessment was completed on 11th November 1998.
A Waterlow score of 24 was recorded on 11th November 1998 and 23rd November 1999.
A Barthel ADL index was recorded on 11th November 1998 scoring 2 and on 23rd November 1998 scoring 1.

11th November 1998

Transfer letter notes Mrs Purnell is catheterised, has bilateral pressure sores on her heels, is eating well but has poor fluid intake. She is to be admitted for rehabilitation but this could be difficult due to her mental state and pressure sores. She is to be admitted for one month initially and unless there is any improvement then she may need to be admitted to a Nursing Home for continuing care.

Clinical notes – transfer from Haslar with senile dementia, pressure sore on heels and oedema of leg. Family aware of poor prognosis.
Summary – admitted from E3 Haslar.

12th November 1998

Clinical notes – In pain despite co-codamol and oramorph.
Summary – complaining of a great deal of pain. Oramorph 5mg given at 14.10 and to be given on regular basis for 24/48 hours.

13th November 1998

Summary – oramorph 10mgs given at 10.25.

14th November 1998

Summary – son concerned very sedated. He is aware of poor condition and that opiates may be needed to control pain.

17th November 1998

Clinical notes – son seen very angry feels his mother is not being cared for adequately and accusing nursing staff of murdering his mother by giving her oramorph. Has been verbally abusive to nursing staff and doctor. On examination Mrs Purnell was semi-conscious and appears to be in distress when moved. Son not happy for any analgesia.
Need to keep comfortable and pain free. Discussion with Dr Lord for IL S/C fluid over 24 hours. Dr Reid coming in to assess situation.
Review by Dr Reid – son has left ward indicating he will complain about his mothers condition. Need to be relieved of pain (despite sons wishes). Nursing staff report choking on food and fluids. Son trying to push food and fluids into mother which she tries to push out with her tongue. (Police should be called if happens again and also if nursing staff are being intimidated.)
Summary – son angry and abusive physically grabbing nurse. Police contacted and incident form completed. Oramorph 10mgs given with good effect.

18th November 1998

Clincial notes – less well, drowsy. Prognosis poor tried to inform son.
Summary – Cheyne stroke respirations feeding inappropriate at present.

20th November 1998

Clinical notes – comfortable – oramorph. **Happy for nursing staff to confirm death.**
Summary – sleepy had been in pain and distress. 15mgs oramorph given.

23rd November 1998

Clinical notes – groaning in pain. Heels thickened skin bilatually, sacrum red but intact on Pegasus airwave mattress and cushions for cot sides. S/C fluid in progress. Hospital manager has had a called from sons solicitors requesting that he visit at 2.00pm.
Use oramorph/diamorphine to keep comfortable if more than 1 injection of diamorphine is required for syringe driver. Feel she is dying – keep free of pain and distress.
Son did not arrive – solicitor informed of condition.

Summary – agitated. Oramorph 10mgs given at 23.40 repositioned 2-3 hourly. Seen by Dr Lord boarded for diamorphine if have more that 1 injection syringe driver to commence.

24th November 1998

Summary – deteriorating syringe driver commenced 20mgs diamorphine.

25th November 1998

Summary – syringe driver recharged 20mgs.

26th November 1998

Summary – syringe driver recharged 20mgs. Son visited PM.

28th November 1998

Clinical notes – further deterioration.

Summary – syringe driver recharged 20mgs.

29th December 1998

Summary – syringe driver recharged 20mgs.

1st December 1998

Clinical notes – remains comfortable.

3rd December 1998

Clinical notes – died 11.30 hours verified by RGN Shaw and Code A

4th December 1998

Clinical notes – coroners office confirm diagnosis of bronchopneumonia and senile dementia. Certificate issued.

Code A

BJC/37
EDNA PURNELL
91

Dementia and fractured neck of femur. In pain and distressed hence the use of opiates. It is difficult to know if the dose of diamorphine via syringe driver needed increasing in the last 24 hours but overall the use of opiates appears appropriate. Would have died without opiates being used.

PL grading A2

Code A

DOCUMENT RECORD PRINT

Officer's Report

Number: R7CZ

TO: REF:
STN/DEPT:

FROM: DETECTIVE CONSTABLE 424 ROBINSON REF:
STN/DEPT: OP ROCHESTER TEL/EXT:

SUBJECT: DATE: 13/04/2004

I visited Michael WILSON at his home address on Saturday 9th January 2004 (09/01/2004) in relation to his mother Edna PURNELL b.18/03/1907, d.03/12/1998 in accordance with the policy log. I provided Mr WILSON with a copy of his mothers medical records and outlined his concerns as per Officers Report 13G.

Mr WILSON made these additional comments.

In relation to his mothers mobility she needed assistance even when walking with a frame. In relation to her feeding herself, her hands were a bit shaky but she could feed herself. She used to drink using a straw.

When his mother was placed in a single room, she was kept in darkness whereas she liked to be in the light.

When he was spoken to in relation to 'feeding his mother' and the medical notes show that a comment "arrest him on a technical charge" was made. This relates to him feeding his mother a sandwich, which she ate!

The charts relating to his mothers intake of food and fluids were 'destroyed' in April 1999 but he had already begun his complaint with the hospital in February 1999 and had attended a meeting with them.

Mr WILSON had wanted to transfer his mother into a BUPA hospital but was informed by a nurse whom he describes as 'massive' that he couldn't as it was "nothing to do with you, you know".

Mr WILSON has prepared a chronological list of events (submitted) which he commenced on 17/02/1999.

He visited Chilworths Solicitors in Gosport the following day and spoke with Mr C Code A who rang the hospital in his presence and told them to make sure that all of Mrs PURNELL's records were up to date and unaltered.

Mr WILSON was not charged for this consultation.

Mr WILSON also notes from his copy of his mothers medical records that the drip which he insisted they set up was taken down the day after he told them he was not returning to the hospital.

He also notes that on 20/11/1998 Dr BARTON has written up that she was happy for the nursing staff to confirm death.

Mr WILSON is happy to receive a letter notifying him of his mothers classification.

DOCUMENT RECORD PRINT

Officer's Report

Number: R13G

TO:
STN/DEPT:

REF:

FROM: Code A
STN/DEPT: FCU FLEET

REF:
TEL/EXT:

SUBJECT:

DATE: 18/12/2002

Death of Edna Irene PURNEL at Gosport War Memorial Hospital 3rd December 1998 (03/12/1998).

On Monday 16th December 2002 (16/12/2002) I visited Mr Mike WILSON aged 66, who is the son of Edna PURNEL born 18/03/1907. Mr WILSON who is not in good health welcomed me into his home and was eager to tell me his story.

He started by explaining to me his own health problems, which he believes, have been exacerbated by the stress he has been under, concerning the circumstances of his mothers death. He is suffering from a heart complaint affecting the main valves and the aorta artery itself.

In the near future he is facing a major heart operation which has a success rate of only about 60%. However this rate is dropping the longer the condition is left. His wife or partner was very concerned that my visit did not over stress him as this is often a trigger for an attack.

Mr WILSON tells me that on 26th October 1998 (26/10/1998) his mother fell and broke her hip and was taken into The Royal Hospital Haslar. Prior to this fall his mother, although 91, was sprightly and had all her wits about her.

After a successful operation Mrs PURNEL made a good recovery and at the time of her transfer to the War Memorial Hospital on the 11th November 1998 (11/11/1998) she was eating and drinking unaided. She was able to walk with the aid of a frame and was able to take herself to the toilet but was accompanied for safety reasons.

Mr WILSON clearly remembers that his mother had refused pain killers in Haslar and had told him that she was relatively pain free.

At this time even though his mother was old, he was very optimistic that she would make a full recovery. He describes his mother as physically improving and mentally aware.

On the 12th November 1998 (12/11/1998) his mother was given oral morphine allegedly for pain relief. At the time Mr WILSON complained, and questioned the use of the pain killers, when clearly his mother did not require them.

On 17th November 1998 (17/11/1998) Mr WILSON again complained that his mother was being sedated and left in the dark permanently. She was clearly dehydrating and to Mr Code A knowledge she was not being fed.
Mr WILSON read in his mothers notes that Dr REED had recorded 'giving her fluids would only prolong her life.'

Mr WILSON complained so bitterly that staff called security and he was asked to leave. However after this incident his mother was provided with what looked like a saline drip.

On the 3rd December 1998 (03/12/1998) Edna PURNEL died. Mr WILSON believes that the cause of death recorded was bronchial pneumonia. Mr WILSON believes that his mother was starved of not only fluids and food, but was given excessive pain killers which had the effect of suppressing her immune system and thus hastened her death.

Mr WILSON is not represented and has no wish to try and claim compensation. However he is passionate that justice needs to be seen to be done even though he quite openly admits that it is not clear what has gone wrong with the system.

Mr WILSON was very thankful to be able to get the full story off his chest. He tells me that his biggest frustration is that in the past no one has been willing to listen to his complaint.

Expert Review

Edna Purnell

No. BJC/37

Date of Birth: Code A

Date of Death: 3 December 1998

Mrs Purnell lived at Addenbroke Residential Home at the time of her admission to the Royal Haslar Hospital to undergo surgery for a fractured neck of femur.

Following the operation on 26 October 1998 and the insertion of a dynamic hip screw, she was admitted to Gosport War Memorial Hospital for rehabilitation on 11 November 1998.

At Gosport War Memorial Hospital Dr Naysmith noted there was a readiness to move quickly from a single dose of Co-codamol to Oramorph in doses of 5 to 10mgs which was given twice most days. Mrs Purnell became very drowsy on Oramorph and from that point her renal functions seem to have diminished.

The syringe driver was started with 20mgs of Diamorphine which was three times the dose Mrs Purnell was receiving orally. At this point she appeared comfortable although semi conscious.

The experts have considered this case to be a natural death albeit that the treatment was sub optimal and that the dose of opioids was markedly escalated in her final few days.

Dr [Code A] notes that in his opinion Mrs Purnell would have died in any event without opiates being used. The medical records make note of the concerns expressed by Mrs Purnell's son as to the treatment that was being provided to his mother.

HAMPSHIRE CONSTABULARY

MARGARET QUEREE

Code A

Margaret Queree

Date of Birth: **2nd August 1910** Age: **84**
Date of admission to GWMH: **29th July 1994**
Date and time of Death: **12.00 hours on 10th October 1994**
Cause of Death:
Post Mortem:
Length of Stay: **74 days**

Mrs Queree's past medical history:-

Osteoarthritis.
Back pain.
Quinsy.
Heart failure.
Jaundice.
Right hip replacement.
Bilateral leg cellulites.

Mrs Queree was born in Gosport and was a widow. She was the eldest of nine children and had five children of her own. Mrs Queree lived in a warden controlled flat until June 1994 when she was admitted to St Vincent House Residential Home. Her daughter, who lived in Gosport, visited regularly. Mrs Queree was admitted to the Queen Alexander Hospital in May 1994 for constipation and overflow. She underwent surgery for PV discharge and pelvic abscesses. She had a permanent colostomy put in place. She was transferred to Gosport War Memorial Hospital on 29th July 1994 for rehabilitation. It was noted that Mrs Queree's sacral area was very red with a small break on sacrum that she was slow to mobilise and had a catheter in situ.

On admission care plans commenced for poor diet and fluid intake, small sacral sore, incontinent, personal hygiene, mobility, colostomy and to settle at night.
A Waterlow score of 14 was recorded on 30th August 1994 and 20 on 2nd October 1994.

29th July 1994

Clinical notes transfer to Daedulus Ward for 1 week rehabilitation. Transfers with 2 nurses and a hoist. Reluctant to mobilise and very depressed.

15th August 1994

Clinical notes – mobilising 10 steps. Eating better. Barthel 7. To be discharged to a Nursing Home.

6th September 1994

Nursing report – offensive discharge from vagina. Dr Beasley informed

7th September 1994

Nursing report – no discharge overnight. Seen by Dr Code A leave well alone at present but should discharge return ? for refer back to surgeon.

12th September 1994

Clinical notes – confused episodic, not mobile, oedema.

Nursing report – to be long stay now.

22nd September 1994

Nursing report – swabs taken to check for MRSA.

26th September 1994

Nursing report - carrier of MRSA.

3rd October 1994

Nursing report – commenced MST.

4th October 1994

Nursing report – MST increased to 20mgs. Daughter seen about deteriorating condition. Warned to expect worst

5th October 1994

Clinical notes. – deteriorated generally, not eating and drinking well. Small dose of opiates (MST) commenced for general distress.

6th October 1994

Nursing report – very agitated and confused. Restless and distressed. Daughter contacted. Syringe driver commenced at 14.10.

7th October 1994

Clinical notes – much more peaceful since S/C analgesia commenced.

10th October 1994

Clinical notes – further deterioration – died peacefully 12.00 midday. Certified by Sister Joines.

Code A

BJC/38
MARGARET QUEREE
84

Had significant medical problems prior to operation for rectovaginal fistula. Urine and vaginal infections after the operation. She appears to have become physically frailer and more confused. She was reported to be in pain when the MST was started at a low dose. After 3 days of MST she was more agitated and distressed. She was then started on a high dose of diamorphine via a syringe driver with 5-fold increase in the relative dose over 2 days. Although she died of the combination of medical problems, the use of opiates and sedation (midazolam) was poor with rapid dose escalation. However the escalation appears to be in response to patient distress and the starting dose was reasonable.

PL grading A2

Code A

DOCUMENT RECORD PRINT

Officer's Report

Number: R7CO

TO: REF:
STN/DEPT:

FROM: DETECTIVE CONSTABLE 424 ROBINSON REF:
STN/DEPT: OP ROCHESTER TEL/EXT:

SUBJECT: DATE: 12/04/2004

I visited Mrs Rita HOARE at her home address on 20th November 2003 (20/11/2003)in relation to her mother Margaret Jane QUEREE b Code A - 10/10/1994. I provided her with a set of her late mother's medical records and outlined the concerns noted in officers report as per the policy log.

Mrs HOARE wished to add the following information.

Dr BARTON didn't discover the cause of Mrs QUEREE's stomach problems, it was the staff at St Vincents Care Home that brought the problem to Mrs HOARE's attention and it was Dr BEASLEY who referred Mrs QUEREE to the QA Hospital for tests. Dr BARTON dismissed Mrs QUEREE's complaints as "fussing".

The operation Mrs QUEREE had at the QA resulted in her having a colostomy bag.

In 1982 Mrs QUEREE had her hip replaced at the King Edward IV Hospital , during which she had a 'bad reaction' and her heart stopped. She also suffered from Osteoarthritis and diverticulitis. Her arthritis was particularly painful.

Mrs HOARE states that in relation to her mother eating, the food tray was placed out of her mothers reach so she used to go in daily to ensure that her mother ate properly.

Mrs HOARE recalls that a nurse she felt was particularly unpleasant was Code A she refers to her as Code A

Mrs HOARE complained at the time to a Dr (not Dr LORD) that her mother wasn't eating on a regular basis and that she was left out in a chair from 7 in the morning until bed time.

Mrs QUEREE was also given a catheter so she didn't have to be taken to the toilet. This caused her a great deal of distress.

At one point there was an infection on the ward and everyone had to 'gown up'. Mrs QUEREE felt that 'everyone' blamed her because she had a colostomy bag which had brought the 'germ in'. This upset Mrs QUEREE immensely.

Mrs HOARE was told of this by a ward maid (cleaner) she cannot recall her name. Mrs HOARE complained to a staff nurse about these comments being made to her mother. This staff nurse (unknown) was very angry at the time and assured Mrs HOARE that she would speak to the staff about it. Mrs HOARE believes that she spoke with the ward supervisor.

Mrs HOARE states she visited daily, morning and evenings so she was aware of her mother's daily condition.

Her mother had told her that when she was put to bed, if she rang for attention then no one would answer.

Mrs HOARE states that on the day she visited her mother and was told that she had been put onto diamorphine due to being in a lot of pain, she had not complained of any pain the previous evening.

She queried the dose and was told by nursing staff that her mother was on a very low dose to settle her down.

Mrs HOARE asked if Dr BARTON had given permission and was told that she had done so over the telephone.

Mrs HOARE describes her mother as being very sleepy as a result of having a bad nights rest the previous night, she had been given a cage to put over her knees to keep the bedclothes off her legs and hence reduce her pain.

When Mrs HOARE returned that evening to visit her mother was drifting in and out of sleep.

On 7th October 94 (07/10/1994) Mrs QUEREE is described as being in a 'deep sleep'. When asked nursing staff told Mrs HOARE that the morphine dose had been increased. When this was queried as Mrs QUEREE hadn't complained of any pain during her family's visits, Mrs HOARE was told "When the morphine wears off she tells us she's in pain".

At this point Mrs HOARE believes her mother was on a syringe driver.

On 8th October 94 (08/10/1994) the family was told that Mrs QUEREE was getting worse.

Mrs HOARE states she couldn't believe the speed of her mothers decline. She wasn't told how much the size of the dose of morphine had been increased but knew that it had been. When she asked a nurse why she had increased the dose, she was told "Because I was told to".

Mrs HOARE describes her mother as being incoherent and mumbling.

Mrs HOARE and her family is concerned that her mother died so quickly.

She states that the authorities kept her mother in hospital whilst they worked out where her mother was going to live after she was discharged as she was going to require 24 hour nursing care.

Mrs HOARE would like to be notified by letter.

DOCUMENT RECORD PRINT

Officer's Report

Number: R8M

TO:
STN/DEPT:

REF:

FROM: DC 2403 TENISON
STN/DEPT: MCIT W

REF:
TEL/EXT:

SUBJECT:

DATE: 24/11/2002

Sir,

On the 23/11/2002 I spoke with Mrs HOARE re Action 199 and her mother Margaret Jane QUEREE *nee* OSBOURNE *DOB* Code A *DOD 10/10/1994.*

Mrs QUEREE was a local lady who married an Army officer and spent time all round the world; she had six children and was a full time housewife. She was widowed in 1986.

In June/July 1994 Mrs QUEREE underwent an operation on her bowel at the QA Hospital. The problem with the bowel had been reported to Dr BARTON Mrs QUEREE's GP, who did nothing until Mrs HOARE insisted that this problem was investigated. After the operation Mrs QUEREE was sent to the GWMH for recuperation and seemed well. She had been prescribed some painkillers for arthritis.

Whilst at the GWMH Mrs HOARE would see her mother everyday, she would help her to eat and spend time with her. Mrs HOARE was told by one of the nurses Code A that she was not allowed to go to the hospital until 2pm. This was because Dr BARTON felt she interfering. Dr BARTON also didn't want Mrs HOARE to accompany her mother when the consultant saw her. However Mrs HOARE continued to visit her mother and see the consultant with her.

Although Mrs QUEREE didn't want to be at the GWMH she is described as being happy and alert on the 05/10/1994. She was looking forwards to the birth of two great grandchildren. Later the same day she seemed very down and by the 06/10/1994 was remaining in bed and was very sleepy. Mrs HOARE spoke with Dr BARTON who told her that her mother didn't have long to live, that she was in a lot of pain and the morphine was helping with this. Mrs HOARE felt that this was a drastic step. On the 07/10/1994 her mother went into a coma. There was no change until the 10/10/1994 when Mrs QUEREE died.

The cause of death was shown as broncholitis and the certificate was signed by Dr BARTON. There was no PM and Mrs QUEREE was cremated. It is clear that there was a long standing disagreement between Mrs HOARE and Dr BARTON over the care of Mrs QUEREE.

DC Code A

Expert Review

Code A

No. BJC/38

Date of Birth: Code A

Date of Death: 10 October 1994

Mrs Queree was admitted to the Queen Alexander Hospital in May 1994 where she underwent surgery for pelvic abscesses. She had a permanent colostomy put in place. She was transferred to Gosport War Memorial Hospital on 29 July 1994 for rehabilitation. As noted by the experts, Mrs Queree had significant medical problems prior to her operation and both urine and vaginal infections after the operation. She became frail and confused and was commenced on Morphine Sulphate. After three days she was then started on a high dose of Diamorphine via a syringe driver with a fivefold increase in the relative dose over two days.

The experts confirm that in their view she died of natural causes. The use of opiates and sedation was rapidly increased although this properly appears to be reasonable in response to the distress demonstrated by the patient.

HAMPSHIRE CONSTABULARY

VIOLET REEVE

VIOLET REEVE

Violet Reeve

Date of Birth: Code A Age: **76**
Date of admission to GWMH: **11th November 1996**
Date and time of Death: **22.30 hours on 14th April 1997**
Cause of Death:
Post Mortem: **Burial**
Length of Stay: **5 months**

Miss Reeve's past medical history:-

CVA left hemiparisis
Obesity
Hypertension
Constipation
Glaucoma in family

Miss Reeve was single and the eldest of three sisters. One sister lived in London and the other lived in Gosport. Miss Reeve spent a lot of time abroad and moved to England in 1939, she left in the 1960's to move to Germany and then returned to live in England finally getting a flat in Gosport. Miss Reeve was described as being obese but neatly dressed.
Miss Reeve was admitted to the Queen Alexander Hospital on 18th October 1996 following a right CVA and was transferred to the Gosport War Memorial Hospital on 11th November 1996 for rehabilitation.

On admission care plans commenced for immobility, elimination, hygiene and to settle at night, theses were reviewed on the 9th March 1997 and further care plans for unable to eat or drink commenced on 1st April 1997 and bruised left calf commenced on 1st March 1997.
A Waterlow score of between 25 – 30 was recorded between the period of 8th November 1996 to 23rd March 1997.
A Barthel ADL index was completed weekly from 8th November to 5th April 1997 scoring 0.

11th November 1996

Transfer letter – admitted to Daedalus ward after stroke. Suffering from low platelets count, obesity and hypertension. It was noted that she was prone to constipation and transferred with the aid of a hoist.

Summary – admitted from Mary Ward Queen Alexander Hospital. Original CVA 8th October 1996 extension 18th October 1996 for gentle rehabilitation. Needs help with all activities of daily living. Catheterised. Transfers with Wessex hoist. Left arm painful. Barthel 0 Waterlow 25 for MRSA screening.

13th November 1996

Summary – MRSA negative.

27th November 1996

Clinical notes – unhappy painful legs, back and rectum.

16th December 1996

Clinical notes – transfer to long term bed.

21st December 1996

Summary – remains drowsy. Seen by Dr Barton possibly suffered a further stroke.

30th December 1996

Clinical notes – long discussion with sisters and niece and explained not improved much in last 2½ months. Agreed she is very depressed but not confused. Leave flat open for a further month.

2nd January 1997

Summary – slipped to floor in present of S/N B Code A could not prevent from slipping to floor. Assistance of 4 to put back to bed. Accident form completed.

3rd January 1997

Summary – Howling from 9-11am diazepam 5mg given at 10.50.

13th January 1997

Clinical notes – much quieter after 6mgs ?. Still agitated in the evenings. Barthel 0 platelets 66. Prognosis poor.

3rd February 1997

Clinical notes – little more to do except prescribed with antidepressants.

28th February 1997

Summary – poor prognosis and outlook explained.

1st March 1997

Summary – heard to be howling. Left leg caught underneath cot sides despite padding. Bruise mark on lower leg and cream applied, to be observed. Accident form completed.

10th March 1997

Clinical notes – still very distressed. Family also distressed would like second opinion from a neurologist. Neurology referral to Dr Code A.
Seen by Code A EMI, slowly introduce oramorph 2.5 mgs.

11th March 1997

Summary – seen by Dr Code A try oral diamorphine, to be observed for Parkinsons side effects.

13th March 1997

Clinical notes – further deterioration.

18th March 1997

Clinical notes – review with Dr Code A drowsy, eyes closed – agree with plan to control/improve behavior with drugs but avoiding sedatives (day time).
Summary – seen by Dr Code A no evidence of brain tumour.

24th March 1997

Clinical notes – Midazolam via syringe driver will eat if fed. Family accepted situation. Oramorph/diamorphine if very distressed if lady dies **nursing staff to confirm death.**

29th March 1997

Summary – distressed throughout morning.

3rd April 1997

Clinical notes – make further swallowing assessment. Seen by SLT swallowing severely reduced.

Summary – seen by SLT at severe risk of aspiration and subsequent chest infection. Nil by mouth.

7th April 1997

Clinical notes – distressed, grimacing and crying out. Floppy left oedematous hand. Blisters breast and sacrum. Add diamorphine to midazolam. Increase dose of diamorphine to keep comfortable. Prognosis poor.

Summary – in view of continues distressed morphine to be added to syringe driver 20mgs.

8th April 1997

Summary – more settled with diamorphine addition to syringe driver.

Deteriorating – family unhappy with care and feeding. S/C fluids commenced.

10th April 1997

Summary – chesty seen by Dr Barton nursed 2 hourly all care.

11th April 1997

Summary – peaceful family staying night. Chesty and bubbly.

13th April 1997

Summary – distressed diamorphine increased to 40mgs via syringe driver with good effect. Nocte – distressed on movement diamorphine increased 50mgs.

14th April 1997

Clinical notes – condition deteriorating 22.30 died peacefully. Pronounced dead by SSN Code A and S/N Code A for burial.

Summary – death confirmed, sister and niece present.

Code A

BJC/40
VIOLET REEVE
76

Stroke with marked left sided weakness and later she developed swallowing difficulties. The main problem was intermittent distressing crying out for no obvious reason. There were 2 second opinions. The first suggested trying regular low doses of oramorph and an antipsychotic agent. The next opinion agreed and said to avoid sedation. It looks as though they found midazolam the best way of controlling this behaviour and therefore continued sedation. When diamorphine was introduced into the syringe driver it was at a lowish dose and kept at that level until the last 24-36 hours. The dose was trebled in the last 36 hours but she was more agitated and it was apparent that she was dying.
The death was because of her medical problems but they did struggle to control her distress and crying out even after taking second opinions.

PL grading A2

Code A

DOCUMENT RECORD PRINT

Officer's Report

Number: R7BJ

TO:
STN/DEPT:

REF:

FROM: DETECTIVE CONSTABLE 424 ROBINSON
STN/DEPT: MCD E

REF:
TEL/EXT:

SUBJECT:

DATE: 31/12/2003

I visited Alexander MOORE at her mothers home address, Code A in relation to Violet Erica Nadjezhda REEVE at 1345 hrs on Tuesday 23rd December 2003 (23/12/2003) in accordance with the police log.

I went through the family concerns and details given as per officers report 13E.

Additional clarification is as follows;

Violet REEVE suffered two strokes, whilst at home. The first was diagnosed by her GP who told her to come back and see him after a month had passed.

The second stroke occurred approximately a week later and an ambulance was called to take Mrs REEVE to hospital Such was her condition that she was able to walk to the ambulance and once at the Queen Alexander Hospital , would walk to the toilet.

Ms REEVE remained at the QA for 10 days during which time she was fully lucid, her left side was affected by the stroke but she still had movement in her body.

Her death was certified by Dr BARTON and the cause given as Bronchopneumonia. The family was told by Dr BARTON that if Ms REEVE developed pneumonia or kidney failure then she would not be resuscitated.

After Ms REEVE became sedated the family were spoken to by a male nurse named Phillip . He informed them that Violet was on diamorphine because she was in pain.

On one occasion the family asked for the medication not to be given on a particular day as a solicitor was coming in order to obtain a signature to allow a power of attorney to manage her affairs.

The solicitor was unable to accept Violet's signature as she felt she was to sedated to be fully aware of the circumstances.

The family were extremely concerned about Violet's condition and enquired about bringing her to their home in London. They were informed that she would not survive the journey and they were not

permitted to do so.

The family were also concerned that Violet wasn't getting any fluids or nourishment and they insisted that a drip be set up in order to hydrate her.

They noticed that the drip did not appear to go 'into' Violet and were subsequently told by staff that the drip was not working and had been put up to appease the family.

They family is happy to receive a letter informing them of the medical teams findings, with a meeting available to clarify any questions afterwards.

I provided the family with a copy of Violet REEVES medical records.

DOCUMENT RECORD PRINT

Officer's Report

Number: R13E

TO:
STN/DEPT:

REF:

FROM: DC Code A
STN/DEPT: FCU FLEET

REF:
TEL/EXT:

SUBJECT:

DATE: 13/01/2003

On 18th December 2002 (18/12/2002) I went to Code A There I saw Mrs Alex MOORE and her elderly mother concerning the death of her aunt at the Gosport War Memorial Hospital on 14/04/1997.

Her aunt Mrs Violet Erica Nadjezhda REEVE born Code A prior to being taken into hospital was living at Homefort House, Gosport. Although elderly and somewhat overweight, Mrs REEVE was quite active and able to look after herself.

On 18/10/1997 she suffered a stroke and was taken into the Queen Alexander hospital for treatment. While at this hospital she made good progress, and after just a few weeks, she was able to eat and drink normally and take herself to the toilet. She was at this time receiving physiotherapy, to which she was responding. I was also told that Mrs REEVE only ever had mild pain killers at QA and never complained to them about being in pain.

At this time the consultant whose name she can't remember was concerned about the level of platelets in her blood.

In mid November 1997 Violet asked to be transferred to the Gosport War Memorial Hospital because it was nearer to her home.

As soon as she arrived she was placed on pain killers, however Violet continued to insist that she was not in pain so after a few days the drugs were withdrawn. While she was at this hospital she received no physiotherapy. According to Alex MOORE and her mother the standard of nursing care was very poor. In particular Dr BARTON had a very callous and cruel attitude towards both the patient and the relatives.

On one occasion they tackled Dr BARTON about Violets treatment and lack of care. They were told that Violet was going to die and that the treatment being given was the best given the circumstances. Apparently, a nurse Code A, was present and witnessed this conversation.

Examples of negligent care are, that on one occasion they gave Violet insulin because they thought that she was diabetic when in fact she isn't.

Also although they were aware that Violet was a vegetarian they continually gave her meat to eat. When they complained to a nurse they were told "We have 60 pence a day to feed each patient and beef is cheap"

Violet continued to decline and was quite often unable to talk and seemed to be sedated.

On 14th April 1997 (14/04/1997) Violet died, no post mortem was carried out. She was buried.

Expert Review

Violet Reeve

No. BJC/40

Date of Birth: Code A

Date of Death: 14 April 1997

Miss Reeve was admitted to the Queen Alexander Hospital on 18 October 1996 following a stroke affecting her left side. She developed marked weakness and later swallowing difficulties. She was transferred on 11 November 1996 to Gosport War Memorial Hospital for rehabilitation.

During the admission she remained very distressed and was seen by Dr Gibb a neurologist.

The experts have concluded that Miss Reeve clearly had a poor prognosis and very difficult mental state problems.

Dr Lord seemed to have decided, not withstanding the advice of Dr Gibb, to continue sedation and the experts concluded that she was likely to be made more comfortable at the end with the treatment regime of Midazolam and Diamorphine.

HAMPSHIRE CONSTABULARY

JAMES RIPLEY

JAMES RIPLEY

James Ripley

Date of Birth: Code A Age:
Date of admission to GWMH:
Date and time of Death: **Still alive**
Cause of Death:
Post Mortem:
Length of Stay:

Mr Ripley's past medical history:-

Diet controlled diabetes
Osteoarthritis
Gout
Hypertension
Mild chronic renal failure
Possible asbestosis.

In August 2002 Mr Ripley was in Gosport War Memorial Hospital. He had worsening renal function. He was breathless.

Code A

BJC/42
JAMES RIPLEY
75

The question here is whether what happened on 9/4/00 was due to excessive use of opiates. He had not received MST for more than 24 hours before that event and he recovered rapidly. Furthermore the A&E record states that the pupils were equal and reactive. They are not recorded as being pin-point.

PL grading A2

Code A

Expert Review

Code A

No. BJC/42

Date of Birth: **Code A**

Mr Ripley was admitted in August 2002 for worsening renal function and pain from osteoarthritic hips. He was started on Morphine Sulphate, the dose of which was increased after twenty-four hours. Having become drowsy he was transferred back to the Royal Haslar as an emergency where he recovered consciousness. The expert opinion concluded that the escalation in Morphine Sulphate was rapid but non negligent.

DAPHNE TAYLOR

HAMPSHIRE CONSTABULARY

Code A

6.50 BJC/47 Daphne Taylor

Date of Birth: Code A Age: **70**
Date of admission to GWMH: **3rd October 1996**
Date and time of Death: **01.25 hours on 20th October 1996**
Cause of Death:
Post Mortem: **Cremation**
Length of Stay: **18 days**

Mrs Taylor's past medical history:-
Hypertension
Vertigo of central origin
Bilateral visual impairment due to ischaemic retionpathy

Mrs Taylor lived with her husband they had a daughter and a son. Mrs Taylor was a retired sub post office manager. Mrs Taylor was admitted to the Royal Haslar Hospital on 29th September 1996 after suffering a stroke. She was transferred to the Gosport War Memorial Hospital on 3rd October 1996 for rehabilitation.

On admission care plans commenced for sleep, pain right arm left leg, PEG feed, bowels, catheter, personal hygiene, immobile, at risk of developing pressure sores, has scratches on left leg and mouth care.
An assessment form was completed noting that Mrs Taylor wore a hearing aid in her left ear, wears glasses and is blind in left eye, unable to walk, is PEG fed and has been catheterised.
A Barthel ADL index was completed with a score of 0 recorded.
A Waterlow score of 20 was recorded.

3rd October 1996

Transfer form – admitted for rehabilitation after CVA, catheterized, drowsy, PEG fed, understands, but has no speech.
Summary - admitted from A5 Haslar to Daedulus ward with left CVA right hemiplegia. NBM swallowing reflex absent. Seen by Dr Barton medications boarded, chesty and rattly.

7th October 1996

Summary – Seen by Dr Barton appears to be in pain, boarded for Fentanyl patches 25mgs every three days. MRSA swab.
Seen by Dr Lord to be referred to dietician and Speech and Language therapy, seen husband not to be transfused.
Clinical notes – poor prognosis aim to maintain BP.

HAMPSHIRE CONSTABULARY

9th October 1996

Summary – in a great deal of pain boarded for 50mgs Fentanyl patches.
Clinical notes – condition deteriorated. **Nursing staff may confirm death.**
Would not use antibiotics but make comfortable.

10th October 1996

Summary – Fentanyl patch renewed as patch applied on 9th fell off.
Authorised by Dr Barton.

11th October 1996

Summary – more settled. MRSA negative.

17th October 1996

Summary – Left arm elbow still very painful on movement. Dr Barton seen
X-ray from Haslar has requested repeat X-ray.

18th October 1996

Summary – AM very unsettled night appeared distressed and in pain. Syringe driver set up with 40mgs diamorphine and midazolam 20mgs over 24 hours.
Fentanyl patch removed appears more comfortable.
PM appears more peaceful and relaxed, no pain, rousable on turning.
Family seen by Dr Barton and informed of poor prognosis. Feed to continue.
Clinical notes – condition deteriorated last night S/C analgesia commenced.

19th October 1996

Summary – condition deteriorating, chesty very bubbly. Diamorphine 40mgs via syringe driver. Husband contacted still wishes feeding to continue.

20th October 1996

Summary – 01.25 hours died peacefully for cremation. Verifed by SSN Tubbritt and S/N Nelson.

Code A

BJC/47
DAPHNE TAYLOR
70

Severe weakness and requirement for gastrostomy feeding following a stroke. The pain was said to be due to contractures down the hemiplegic side. Other analgesics were not tried before fentanyl and then diamorphine pump. The pain of contractures might have responded to other forms of medication and not so well to opioids. She had severe medical problems and would have died soon. Sedation from the opioids could have made her more susceptible to not being able to clear her own secretions or developing a chest infection.

PL grading A2

Code A

DOCUMENT RECORD PRINT

Officer's Report

Number: R7N

TO:
STN/DEPT:

REF:

FROM: DC 424 ROBINSON
STN/DEPT: MCIT E

REF:
TEL/EXT:

SUBJECT: OPERATION ROCHESTER

DATE: 29/01/2003

Code A 20/10/1996

I visited John Denis Estcart TAYLOR , the husband of the above, at his home address, Code A Code A on 29th January 2003 (29/01/2003).

Mr Code A will say that his wife was born in Corby, they were married in 1946 and had three children. John TAYLOR (Code A Code A Code A Sandra TAYLOR Code A She worked in the textile industry in her teens and upon starting her family remained at home.

The family moved to run the Fleet Post Office in 1974 and Mrs TAYLOR helped in the running of it.

She retired with her husband to their Stubbington address in 1986.

Mrs TAYLOR is described as being fit and healthy. She smoked throughout her life, approximately ten cigarettes a day.

In 1965 she had a hysterectomy and in 1994 attended Haslar Hospital, Gosport for an operation to try and establish a reason for reoccurring headaches. Nothing was found as a result of the examination but the headaches appeared to decrease.

Mr TAYLOR also believes that his wife had a scan to try and establish the cause of her headaches.

In September 1996 Mr TAYLOR discovered his wife lying on the floor next to her bed. She was conscious but incoherent.

Mrs TAYLOR was taken to Haslar Hospital where she remained for two weeks under the care of Surg. Comm. Code A She was diagnosed as having suffered a stroke which had left her without speech and unable to swallow. Her left hand was frozen in a claw shape.

Whilst at Haslar Mrs TAYLOR began to improve considerably but had to be fed via a tube inserted in her nose. She was prone to pulling out the tube and so a tube was inserted directly into her stomach.

Mr TAYLOR states that although his wife could only mumble she was able to understand everything said to her and could make herself understood.

After two weeks Mrs TAYLOR was assessed by Dr LOGAN who informed Mr TAYLOR that he believed Mrs TAYLOR would make a good recovery.

This was also the view of Dr Code A The decision was made to move Mrs TAYLOR to the Gosport War Memorial Hospital , Gosport. Mr TAYLOR didn't travel with his wife to GWMH but visited her shortly afterwards.

He discovered that his wife had been placed in Daedalus Ward and went to speak to staff to find out where her bed was. He was spoken to by a female member of staff, he believes she was the ward sister and that her name was Code A She said to him "Do you want me to keep feeding her?".

Mr TAYLOR assured her that he did and went to see his wife who was propped up in bed and appeared happy and comfortable. She clearly recognised her husband.

Mr TAYLOR visited his wife daily and was concerned that his wife was not receiving the remedial treatment that she had whilst at Haslar, namely physiotherapy twice a day.

On Thursday 17th October 1996 (17/10/1996) Mrs TAYLOR is described as being alert and comfortable, she beckoned her husband back to her for a hug at the time of his departure.

On Friday 18th October 1996 (18/10/1996) when Mr TAYLOR visited he found his wife lying on her right side with what he describes as a 'pump' lying on her chest. Mrs TAYLOR was 'asleep' and didn't awake again.

On Saturday 19th October 1996 (19/10/1996) Mr TAYLOR asked if he should notify his family members for them to visit and was told that he should.

On Sunday 20th October 1996 (20/10/1996) the family visited during the morning. He believed that his wife was lying in exactly the same position. It didn't appear that she had been moved since the Thursday.

At 12.15 hrs the same day Mr TAYLOR received a telephone call from the hospital informing him that his wife had died.

Daphne TAYLOR's death certificate was signed by J A BARTON BM and gives 1(a) Bronchopneumonia, ii Cerebrovascular accident as her cause of death.

She was cremated.

Mr TAYLOR believes that the female Dr from the Lee Health Centre was his wife's Dr.

His concerns are that his wife was killed by painkillers administered via the 'pump '.

He believed that his wife would make a good recovery and would eventually be well enough to leave the

hospital.

DOCUMENT RECORD PRINT

Officer's Report

Number: R7BF

TO:
STN/DEPT:

REF:

FROM: DETECTIVE CONSTABLE 424 ROBINSON
STN/DEPT: MCD E

REF:
TEL/EXT:

SUBJECT:

DATE: 09/12/2003

I visited John TAYLOR at his home address at 1100 hrs, Monday 8th December 2003 (08/12/2003) in relation to his wife Daphne Rita TAYLOR [Code A] - 20/10/1996 and in accordance with the policy log.

I outlined his concerns as per report 7N and supplied him with a copy of his wife's medical records.

He further added, why was his wife given the pump, she had not complained of any pain.

She was not eating enough at GWMH but had a peg fitted so why didn't they increase her nourishment.

When he saw her after her death, all the blood had drained to the right side of her face where she had been lying since the 18/10/1996.

Mr TAYLOR is happy to receive a letter or a telephone call.

Expert Review

Code A

No. BJC/47

Date of Birth: Code A

Date of Death: 20 October 1996

Mrs Taylor was admitted to the Royal Haslar Hospital on 29 September 1996 after suffering a cerebrovascular accident. She was transferred to the Gosport War Memorial Hospital on 3 October 1996 for rehabilitation.

On 7 October 1996 Mrs Taylor was felt to be in pain and was prescribed Fentanyl patches.

Mrs Taylor was noted to be in a great deal of pain and the strength of the Fentanyl patches were increased.

On 18 October, following a very unsettled night when Mrs Taylor appeared to be distressed and in pain, a syringe driver was set up with 40mgs of Diamorphine and 20mgs of Midazolam over twenty-four hours.

Although Mrs Taylor had a severe stroke which left her unable to swallow or speak, she was being tube fed. However, she was prescribed rapidly escalating doses of opioids without there appearing to be a comprehensive assessment made for her pain.

The experts note that she had an irrecoverable cerebrovascular and would have died soon in any event.

HAMPSHIRE CONSTABULARY

FORMAT OF FILE CONTENTS

1. DOCUMENT LISTING THE CONTENTS OF THREE BOXES DELIVERED TO GENERAL MEDICAL COUNCIL

2. REVIEW OF EXPERTS (WHERE AVAILABLE)

   A.
   B.
   C.
   D.

Code A

3. POLICE OFFICER'S REPORT

4. CASE REVIEWS BY (WHERE AVAILABLE) Code A

CONTENTS OF BOXES TO GENERAL MEDICAL COUNCIL

REF.	NAME	FILE CONTENT
BJC/76	JOHN RITCHIE	COPY OF MICROFILM PAPERS
BJC/87	JACK RITCHIE	COPY OF MICROFILM PAPERS
BJC/85	ARTHUR COUSINS	COPY OF MICROFILM PAPERS
JR/9	ARTHUR COUSINS	COPY OF PAPER RECORDS
BJC/84	LILLIAN TAYLOR	COPY OF PAPER RECORDS
JR/8	LILLIAN TAYLOR	COPY OF PAPER RECORDS
BJC/86	CHRISTINA TOWN	COPY OF MICROFILM RECORDS
BJC/91	ALFRED LEE	COPIES OF PAPER AND MICROFILM RECORDS

BJC/92 & JR/20	EDITH HILL	COPIES OF PAPER RECORDS
BJC/46	JEAN STEVENS	COPIES OF PAPER AND MICROFILM RECORDS
JR/4	JEAN STEVENS	COPY OF PAPER RECORDS
BJC/41 & JR/10	GLADYS RICHARDS	COPIES OF PAPER RECORDS
BJC/20	LEONARD GRAHAM	COPIES OF PAPER RECORDS

HAMPSHIRE CONSTABULARY

JOHN RITCHIE

Code A

Code A

Code A

DOCUMENT RECORD PRINT

Officer's Report

Number: R7C

TO:
STN/DEPT:

REF: NO LAWSON

FROM: DC 424 ROBINSON
STN/DEPT: Operation Rochester

REF: NO LOHN
TEL/I

SUBJECT: John Ralston RITCHIE b.07/06/1899

DATE

On 12th November 2002 (12/11/2002) I visited Shirley BOWSHER (Nee RODDIS) at her home address of Code A. In response to her contacting the police in relation to this operation.

Mrs BOWSHER was a neighbour of John RITCHIE and used to 'look in' on him daily when he was living at home, Code A and thereafter visited him on a weekly basis after he was admitted to the Redcliffe Annex, GWMH.

Mrs BOWSHER having seen the publicity surrounding the investigation, felt that Mr RITCHIE's details should be given to the enquiry team.

Mrs BOWSHER will say that John RITCHIE (also known as Jock and Jack) lived alone at the Portsmouth address. He was a very independent gentleman who was well known in his local community and very popular.

She believes that he was married and had been separated many years before but had never divorced his estranged wife (no other details known).

Mr RITCHIE's only next of kin are: Ted and Jennie BLATT, 277 Watchung Ave, North Plainfield New Code A. Jennie BLATT being his niece. His relatives are not aware of this enquiry and do not know that Mrs BOWSHER has contacted us.

Mrs BOWSHER knew Mr RITCHIE for around 15-17 years, she never knew him to be ill, with the exception of a 'touch of pneumonia' from which he made a full recovery.

A couple of months prior to his death, Mr RITCHIE, began to fall whilst at home. He wouldn't use a walking stick or zimmer frame and had become unsteady on his feet. It was around this time that Mr RITCHIE was admitted to the Queen Alexandra Hospital, Cosham, Hants. Mrs BOWSHER cannot recall the reason for his admission or the ward he was in.

From the QA he was discharged to the Redcliffe Annex in Gosport. The reason given there was a shortage of beds at the QA.

DOCUMENT RECORD PRINT

Mrs BOWSHER believes this was a few weeks before he died. She puts his date of death as 22/10/1994.

Mrs BOWSHER would visit Mr RITCHIE on a weekly basis, going every Sunday with another neighbour, Gwen GRAHAM (Code A

She states that Mr RITCHIE had been given a tube so that he didn't have to be moved to wee (catheter) and that he spent all of his time in bed.

He appeared well at first but shortly afterwards the nursing staff told them that Mr RITCHIE had a chest infection, which was understandable as he spent a lot of time in bed. The nurse said that he had been given antibiotics.

On a visit shortly afterwards Mrs BOWSHER noticed that Mr RITCHIE appeared unwell and had 'gone downhill'. He wasn't 'with it' and wasn't paying much attention to what was going on around him.

They asked the nursing staff what was wrong with him but were told that his case couldn't be discussed as they were not relatives (they were however, his only visitors).

The following week Mr RITCHIE was 'very sleepy' and 'out of it' Mrs BOWSHER saw a black patch on the right side of Mr RITCHIE's chest, under his pyjamas and on his skin. When they asked staff why he was sleeping so much, they were told that he was 'very afraid of dying'.

Mrs BOWSHER assumed that the patch was some sort of sedative.

Mr RITCHIE fell into a deeper and deeper sleep, the neighbours stayed with him until late into the night and the following morning received a call from the annex to say that he had passed away.

Mrs BOWSHER never saw the death certificate and doesn't know why John RITCHIE died. She says that he was a social case and just needed someone to look after him.

She believes that Mr RITCHIE's GP came from the surgery in Fratton Rd near to the Co-Op.

Mr RITCHIE was buried in Kingston Cemetery .

HAMPSHIRE CONSTABULARY

ARTHUR COUSINS

Code A

BJC85/JR9 Arthur Cousins
Date of Birth: Code A Age: Code A
Date of Admission to GWMH: **10th July 2000**
Date and time of Death: **00.45 hours on 25th August 2000**
Cause of Death: **1. (a) Chronic obstructive pulmonary disease**
2. Squamous slow growth Carcinoma diagnosed in Dec 1999. (carcinoma of lung)
Post Mortem:
Length of Stay: **47 days**

Mr Cousins past medical history was noted to be:-

- Malaria/hepatitis – war
- COPD
- Diverticular disease – 1992
- Soft tissue injury left wrist - 1993
- Achilles tendonitis – 1995
- Atrial fibrillation – 1999
- Colonscopy – 1999
- BCC left forehead – 1999
- Carcinoma lung - 1999

Mr Cousins was bought up in Gosport. He was one of a large family and only had a sister alive. Before the war he was employed as a joiner working on building sites. During the war he was in the Royal Hampshire Regiment and travelled throughout Europe. During his time in the war he contracted malaria and hepatitis and sustained a neck injury. He returned from the war and continued working as a joiner. Mr Cousins was married for over 50 years he had two sons and a daughter. His wife [redacted] They lived in a three-bedroom house with a stair lift.
Mr Cousins was admitted to the Royal Haslar Hospital on 19th June 2000 with increasing shortness of breath. He had undergone a pleural biopsy, which revealed he had lung cancer in November/December 1999. On 19th June 2000 while at Haslar he sustained a fall and fractured his sternum. Mr Cousins was transferred to Gosport War Memorial hospital on 10th July 2000.

On admission care plans commenced for hygiene, constipation, sleep, and catheter care. (page 314 to 331). A handling profile (page 334/335) was completed noting that Mr Cousins was unsteady, had chest pain as result of fall, needed the help of 1 nurse and a zimmer frame. A nutritional screening (page 332/333) score of 13 was recorded noting Mr Cousins was at risk. A mouthcare assessment (page 336) was completed. A waterlow score (page 338) and barthel ADL score (page 340) was recorded weekly from 12th July 2000 until 21st August 2000.

Daily summary

10th July 2000

Clinical notes – transfer from Haslar. Fell whilst inpatient onto face and chest. Fractured sternum. At present SOB not mobilising. Cough, chest wheeze and chest pains. (page 268/239/270/271/272)

Clinical notes – painful left shoulder and right leg weakness. (page 272) Referred to physio. (page 20/21)

Summary of significant events – transfer from A5 RHH at 11.30am. Excerboration of COPD, AIF, SOB. Suffered a fall during stay on A5 and fracture to sternum. On regular analgesia and regular nebuliser due to SOB. Oxygen therapy 24%/3 litres to be given PRN. Satisfactory admission. Seen by Dr Wilson ECG performed MRSA swab sent to lab. **Patient unaware of cancer.** Dr Wilson examined Mr Cousins right leg weakness present. **? CVA ?? due to cerebral metastases.** (page 302)

Nocte – 3 episodes overnight requiring oxygen. (page 302)

12th July 2000

Clinical notes – complaining of left sided chest pain. Plan PRN oramorph and monitor. (page 273)

Summary of significant events – complaining of left sided weakness radiating to left arm. Looks anxious, dysphonic, expectorated small amount of sputum. Seen by Dr Wilson to monitor. (page 302)

Summary – for oramorph PRN Pulse 130 irregular. X-ray right leg to be done. Right leg very swollen erytheme present, very small blister present to back of heel. Right foot very swollen to be kept elevated. Referred to physio. (page 302/303)

14th July 2000

Clinical notes – x-ray report left shoulder and right hip – bony injury. (page 273)

17th July 2000

Clinical notes – chesty – abdomen difficult examination discussion with Mr Cousins re wife's [redacted] (page 274)

Summary of significant events – **seen by Dr Wilson in great deal of pain and very distressed. Oxygen given. Oramorph 5mgms given at 12.15 hours** with good effect may be repeated 4 hourly as necessary. (page 303)

18th July 2000

Clinical notes – cough/yellow sputum. Using PRN oxygen. Plan to continue with steroids, analgesia and becloforte. GP appointment booked but deferred until discharge. (page 275)

20th July 2000

Clinical notes – reviewed. Continues to complain right-sided abdo pain. Bowels opened. On examination comfortable at rest transfers independently to bed. Ankle oedema ++. ? constipated. (page 276)

24th July 2000

Clinical notes – well pain settled. Had increasing shortness of breath. (page 277)

Summary of significant events – experienced some dysphonic at 12.15 hours nebuliser given. Some relief. Became more dysphonic and cyanosed. Dr Code A informed. No complaints of chest pain. Nebuliser given. Condition improved. (page 303)

25th July 2000

Clinical notes – coughing up sputum. Antibiotics. (page 278)

Summary of significant events – seen by Dr Code A predrusilone increased. Sputum specimen to be obtained. (page 304)

7th August 2000

Clinical notes – bowel opened x 6 yesterday. On examination pulse 98 irreg. Refer to phsyio. (page 279)

8th August 2000

Clinical notes – feeling well on PRN oxygen nocturnal. (page 279)

Summary of significant events – seen by Dr Code A to be referred to physio. (page 304)

11th August 2000

Clinical notes – SOB pain left side chest. Diagnosed with anxiety. Has been offered oramorph but declined. (page 280)

Summary of significant events – became very short of breath. Appeared to have ? panic attack. Nebuliser given with effect. Remain panicky. Visited and examined by Dr Beasley. Diazepam 5mg PRN. Same given at 23.00 hours. Sat up in bed with 24% oxygen. Eventually settled. Anxious when awake requires a lot of reassurance. (page 304)

13th August 2000

Summary of significant events – continues to have episodes of SOB. Diazepam PRN over weekend. Oxygen used as required. (page 304)

18th August 2000

Clinical notes – SOB/anxious/bed night. [redacted]

Gets very tearful no cure for his chest. Plan to increase steroids, humidified oxygen, **reg oramorph 5mg** and PRN diazapam/midozolam. (page 281)

Discussion with Mr Cousins re treatment may have to go to acute ward at Haslar or Queen Alexandra to be ventilated. Advised not the right thing to do he agrees to stay at GWMH and has agreed to try morphine. (page 282)

Summary of significant events – 11.15 hours became very agitated and anxious. Son told him his wife [redacted]. Complained of feeling unwell. **Oramorph 5mgs given with good effect.** Nocte – now boarded for oramorph on **a regular basis. 10mg given at 22.00 with effect.** Awake at 2.30 hours anxious and distressed. Oxygen given became less anxious at 05.30 hours. Complaining of chest and abdo pain. Prescribed neb plus **oramorph 5mg** given with effect now settled. (page 305)

19th August 2000

Summary of significant events – continues on **regular oramorph** family have visited and aware of poor prognosis. (page 305)

20th August 2000

Summary of significant events – further deterioration extremely anxious causing SOB. **Arthur has agreed to try syringe driver for 24 hours.** Remains concerned that he will become addictive to morphine – reassurance given that he will not. (page 305) **Syringe driver commenced at 12.40 hours with diamorphine 10mgms and midazolam now needs almost continuous oxygen.** (page 306)

21st August 2000

Clinical notes – agitated evening started **midozolam and diamorphine S/C** syringe driver. **If Mr Cousins passes away nursing staff may certify.** (page 282/283)

Summary of significant events – poor condition remains. More settled occasional episodes of SOB and anxiety. Driver recharged at 11.10 hours with 10mgs diamorphine and midazolam 20mgs. (page 306)

22nd August 2000

Summary of significant events – seen by Dr Code A on round. Abdomen very distended. **Syringe driver recharged at 15.50 hours.** 17.30 hours very twitchy and agitated. **Complaining of pain driver recharged with diamorphine 20mgs and midazolam 30mg hyoscine 40mcgs.** 18.10 hours became very distressed and agitated. ***Diamorphine 10mg IM given.*** Oxygen almost continuous. 20.00 hours more settled, less agitated and now peaceful. Family visited. 03.00 hours settled night. **Syringe driver continues as prescription.** Abdomen remains distended. (page 306/307)

23rd August 2000

Summary of significant events – all care given. Syringe driver satisfactory peaceful. 16.15 hours syringe driver recharged **diamorphine 30mgs midozalam 40mg and hyoscine 400mcg.** The increase in drug therapy was due to Arthur becoming quite distressed particularly whilst being attended to. (page 307)

Night – comfortable night initially but became quite distressed and very much pain on movement/turning. **Syringe driver charged to 40mg diamorphine as beginning to be bubbly.** Oxygen given continuously overnight. Mouthcare given – mouth and lips very dry. (page 308)

25th August 2000

Summary of significant events – 00.10 comfortable although left leg and lower abdomen becoming quite mottled. 00.40 condition deteriorated suddenly. 00.45 died peacefully. Family informed. (page 308)

Clinical notes – condition continues to deteriorate died peacefully at 00.45 hours. Death certified by SS/N A Tubbritt witnessed by HCSW I Code A Family informed. (page 284)

Operation Rochester. Clinical Team's Assessment Form				
Care Death/Harm	Optimal 1	Sub Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A	1A			
Unclear B				
Unexplained by Illness				

Code A

DOCUMENT RECORD PRINT

Officer's Report

Number: R7EP

TO:
STN/DEPT:

REF:

FROM: DETECTIVE CONSTABLE 424 ROBINSON
STN/DEPT: OPERATION ROCHESTER

REF:
TEL/EXT:

SUBJECT:

DATE: 11/10/2004

The Key Clinical Team met and discussed the following cases on Saturday 9th October 2004 (09/10/2004). All team members were present Code A BJC/84 [illegible] 2A.
The individual marks are as follows: Code A Code A 2A
Code A 2b.

Arthur COUSINS BJC/85 & JR/9 1A.

All teams members scored the same.

Christina TOWN BJC/86.

Noted that Mrs TOWN never received any opiates but was prescribed 40-200mg Diamorphine. Because of this she is scored as a 2A. Individual scoring is as follows A.NS=1A, PL-2A, R.F-2A, IW-2A.

DOCUMENT RECORD PRINT

Officer's Report

Number: R7EP

TO: REF:
STN/DEPT:

FROM: DETECTIVE CONSTABLE 424 ROBINSON REF:
STN/DEPT: OPERATION ROCHESTER TEL/EXT:

SUBJECT: DATE: 11/10/2004

The Key Clinical Team met and discussed the following cases on Saturday 9th October 2004 (09/10/2004). All team members were present, Lillian TAYLOR BJC/84 & JR/8 was marked as 2A. The individual marks are as follows: Code A 2A, Code A 2A, Code A 2A and Code A 2b.

Arthur COUSINS BJC/85 & JR/9 1A.

All teams members scored the same.

Christina TOWN BJC/86.

Noted that Mrs TOWN never received any opiates but was prescribed 40-200mg Diamorphine. Because of this she is scored as a 2A. Individual scoring is as follows A.NS=1A, Code A 2A, R.F-2A, IW-2A.

LILLIAN TAYLOR

BJC84/JR8 Lilian Taylor

Date of Birth: Code A Age: 84
Date of Admission to GWMH: **21st January 2000**
Date and time of Death: **05.30 hours on 14th February 2000**
Cause of Death:
Post Mortem: **No**
Length of Stay: **24 days**

Mrs Taylor's past medical history was noted to be:-

- Bilateral cataracts extraction
- Thyroidectomy
- Ischaemic heart disease
- Atrial fibrillation
- Hypertension
- Mild stroke with left hemiparesis
- Right axillary thrombosis

Mrs Taylor was a widow and had 5 children. She lived alone in a ground floor council flat and managed very well. She was very independent and did not smoke or drink. Mrs Taylor was diagnosed with cancer of the stomach and underwent a subtotal gastrectomy on 12th January 2000 at the Royal Haslar Hospital. She spent five days in the high dependency unit and admitted to Gosport War Memorial Hospital on 21st January 2000 for palliative care.
The transfer letter (page 245) may have been written by a nurse.
On admission to Gosport care plans commenced for sleep, catheter, hygiene, sacral area red/broken area, elimination, wound site, reduce diet/vomiting. (pages 265 to 279) A waterlow was completed with a score of 14 recorded rising to 22 on 11th February 2000. (page 285) A barthel ADL index was also completed with a score of 15 noted and then reducing to 3 on 11th February 2000. (page 287) A nutritional screening tool was completed noting a score of 14. (page 283/284) A handling profile was also completed noting that Mrs Taylor had abdominal discomfort, wears glasses for reading and watching television, usually independent and complaint. That the wound site was clean and dry but the drain site leaking. It also noted that Mrs Taylor was nursed on an air mattress, that she walks with the aid of a stick, needed the help of nurses to help her into bed and a hoist for a bath. The later evaluation noted that Mrs Taylor needed help turning in bed by 2 nurses and that she had been unable to get out of bed and had been catheterised. (pages 289/290/291)
Stopped Warfarin in December 1999 to reduce risk of embolus.

Daily summary

21st January 2000

Summary of significant events – admitted from D3 Haslar. She was to be admitted to the GP Unit. Dr Barton was the GP on Sultan.Had subtotal gastrectomy for CA stomach on 12th January 2000. Spent 5 days in HDU stopped warfarin in December 1999. **On arrival mobile with stick,** hypertension. She was independently mobile with a poor appetite. 21st January 2000. Independent with hygiene, wound clean and dry, drain site slightly leaking nepore dressing in situ. Legs dry and oedematous. Appetite poor on puree liquid diet. Food and fluid chart commenced. (page 193)

14th January 2000

Clinical notes – difficulties with food and fluid intake. For OT assessment for social services. (page 73)

Summary – 13.45 seen by Dr Barton to have extra cheese in evening to improve protein. (page 193)

25th January 2000

Clinical notes – abdo pain overnight. BS present no vomiting. Abdo soft. PM – **vomited with old coffee if fresh blood appears will need transfer.** (page 73)

Summary – *08.40 hours seen by Dr Barton* **commenced on ciproxin for kidney infection.** Mrs Taylor feeling generally unwell. 13.30 vomited coffee ground vomit. 14.45 hours BP 170/90 pulse 104 temp 38 paracetamol given. 15.00 hours seen by Dr Knapman to treat nausea with IM or oral metaclopramide PRN if vomits fresh blood for transfer to RHH. Dr Barton to review tomorrow. (page 193)

26th January 2000

Summary – no further episodes of vomiting. 11.45 hours small amount of vomit and blood. Nocte – small amount of vomit containing blood. Diarrhoea overnight. (page 194)

27th January 2000

Clinical notes – had sub total partial gastrostomy on 11th January 2000 since having become **nauseous and has vomited small amount of frank blood. Is in pain and frightened.*** (page 73/74)

Summary – seen by Dr Barton referred to Code A **Discontinue aspirin** and antibiotic tomorrow. (page 194)

28th January 2000

Clinical notes – **palliative medicine at Countess Mountbatten house** Code A Code A) recommend haloperidol 1.5mg nocte for nausea. **Comfortable aware that her operation was for possible malignancy. She states does not know result of surgery nor does she wish to. Continue current management with encouragement of mobilising and rehab*.** (page 74)

* **N.B.*Contrast between 2 opinions about this lady within 24 hours.***

Summary – seen by Dr Barton who spoke with son. 20.00 hours seen by Code A Code A said bright and alert, boarded for haloperidol 1.5mg nocte increased to BD if not effective or consider S/C infusion of haloperidol or cyclizine. Patient is aware of diagnosis/prognosis but does not wish to confront or discuss this. (page 194)

30th January 2000

Summary – **complaining of pain in right calf no redness.** Healthcare asked to visit. 18.00 hours healthcare contacted again will visit asap. Pyrexia 38.4 NOK informed who was very upset on phone. 18.40 hours in consultation with Haslar and Accident and Emergency ambulance called. Transfer to Haslar NOK notified. 22.00 hours returned from Haslar ? **DVT/?chest infection.** Complaining of pain left lung area. For U/S tomorrow. (page 195)

31st January 2000

Summary – complaining of pain right calf. Left leg more oedematous than right up to sit in chair. Very poor apyrexial. 13.30 hours seen by Dr Barton for palliative care. (page 195)

1st February 2000

Clinical notes – USS booked for 2nd February. Still nauseated controlled by haloperidol ? needs increase tomorrow. (page 74)

Summary – U/S arranged for tomorrow. **Seen by Dr Barton if nausea persists haloperidol maybe increased to 5mgs over 24 hours via syringe driver.** (page 196) *(Gosport notes)*

2nd February 2000

Clinical notes – haloperidol increased 5mg S/C in 24 hours if remains cheerful over weekend return to oral. ? needs referral to social services. (page 75/76)

Summary – seen by Dr Barton no DVT seen on U/S at RHH. Syringe driver increased to 5mgs over 24 hours. If nausea settles reduce to 2.5mgs and reduce to oral medication once condition stabilised restart social services referrals. (page 196)

Seen in A&E at H**4th February 2000**

Clinical notes – still vomiting profusely and remains pale and unwell. Wound she be candidate for continuing care in hope we might get her home. (page 75/76)

Summary – seen by Dr Barton for referral to elderly services ? possible transfer to Dryad ward for ? care. (page 196)

7th February 2000

Clinical notes – seen by Dr Lord – suggest increase haloperidol to 4-5mg S/C in syringe driver over 24 hours. If in pain S/C diamorphine 2.5-5mg PRN 4 hourly. Aware she is poorly. Best on Sultan Ward for next week, as she will deteriorate rapidly. (page 75/76)

Summary – seen by Dr Lord increase haloperidol S/C via syringe driver 4.5 over 24 hours. (very frail) If in pain for SC diamorphine 2.5-5mgs S/C 4 hourly PRN. Oral fluids as tolerated will leave on Sultan Ward for next week. (page 196)

10th February 2000

Summary – 12.15 hours S/C site resited 5mg diamorphine and 5mg haloperidol commenced over 24 hours as complaining of pain. (page 197) Stopped Aspirin and Digioxin.

11th February 2000

Received 5 mgms diamorphine.

12th February 2000

Clinical notes – further deterioration having small amount of diamorphine S/C. Seems comfortable. (page 75/76)(*early morning round*)

Summary – right leg looking cyanosed specifically toes.(*possible embolism again*) Leg warm but toes cold. Mrs Taylor complaining of aching leg. Dr Barton informed.

11.40 increased to 20 mgms Diamorphine. (*Ischaemia is bad pain.*)

Nocte – syringe driver site has pinpoint of redness slept well. (page 197)

14th February 2000

Clinical notes – 05.30 hours condition deteriorated died peacefully. Verified by S/N Code A in the presence of N/A Code A Relatives informed. (page 75/76)

Summary – 05.30 died peacefully son informed will visit. (page 197)

Operation Rochester. Clinical Team's Assessment Form				
Care Death/Harm	Optimal 1	Sub Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A		2A		
Unclear B				
Unexplained by Illness				

Code A

DOCUMENT RECORD PRINT

Officer's Report

Number: R7CD

TO: REF:
STN/DEPT:

FROM: DETECTIVE CONSTABLE 424 ROBINSON REF:
STN/DEPT: MCD E TEL/EXT:

SUBJECT: DATE: 19/02/2004

I visited Eileen GOITCH at her home address at 1500, Thursday 18th Feb 04 (18/02/2004) in relation to her mother Lilian Madeline Victoria TAYLOR b. Code A

I explained the reason for the delay in our contacting her to obtain details and note her concerns. She is happy knowing that the relevant records will be retrieved and analysed. Mrs TAYLOR (nee THOMAS) had been married to Claude TAYLOR and had three children, Allan Claude TAYLOR , Code A Code A - surname not known. Code A , address unknown possibly lives abroad and Peter Raymond TAYLOR Code A

Mrs TAYLOR was born in Portsmouth and worked as a tailoress. She left her husband and children and lived with Richard DONOVAN having a daughter, Eileen. The family moved to London an Code A worked on the seagoing liners as a stewardess.

She retired at 60 and moved to Gosport where her GP was Dr BARTON and her last address was Code A Code A She is known to have suffered from high blood pressure and had a goyter removed from her neck.

Mrs GOITCH recalls that her mother was not happy with Dr BARTON and had complained that she had refused to come to Mrs TAYLOR's house on a number of occasions when she had been called.

On 11th December 1999 (11/12/1999) Mrs GOITCH called her mother to wish her a happy birthday to discover that her mother was unwell and an ambulance had been called by a neighbours Dr after Dr BARTON had refused to attend when her mother had been taken ill.

Mrs TAYLOR was taken to Haslar Hospital where she was diagnosed as suffering from anaemia. She had been complaining of indigestion and Dr BARTON wouldn't give her anything to relieve it. Tests carried out at the hospital showed that Mrs TAYLOR had a blockage and she was allowed home for the Christmas period. She returned to Haslar in the January and underwent surgery to remove the obstruction. The operation was a success and the doctors there were 'very pleased' with her progress. Mrs TAYLOR was transferred to the Gosport War Memorial Hospital on 21st January 2000 (21/01/2000) for rehabilitation and recuperation.

Mrs GOITCH rang her mother daily and initially she sounded lucid and in good spirits, however as time

DOCUMENT RECORD PRINT

went on she sounded progressively worse during these conversations. She would complain of being in pain and her speech appeared to be laboured.

Mrs GOITCH last spoke to her mother on 13th February 2002 (13/02/2002) and she described her as being incoherent and drowsy.

On 14th February 2000 (14/02/2000) Mrs GOITCH was contacted by the hospital and informed that her mother had died.

Mrs GOITCH remembers on one occasion phoning the GWMH and being told that her mother had been taken back to Haslar and then discovering that she had been returned to the GWMH on the same day. She wasn't told the reason for this.

Mrs GOITCH son Nick, rang the hospital in order to speak with Dr BARTON, the family had concerns as to the speed of Mrs TAYLOR's deterioration. Dr BARTON told him "Well if you've got a complaint report me".

Mrs TAYLOR's cause of death is given as:

1a Carcinomatosis
b Carcinoma of stomach
ii Ischaemic heart disease

The certificate was signed by Dr J BARTON. Mrs TAYLOR was cremated at Portchester Crematorium. The family's concerns are that Mrs TAYLOR deteriorated very quickly after making such a good recovery at Haslar and that having obtained a copy of Mrs TAYLOR's medical notes, there is no mention of Ischaemic heart disease in them.

Mrs GOITCH states that whereas she was unable to visit her mother on a regular basis due to the distance, her brother Peter, visited regularly and would be better placed to comment on the circumstances at the hospital.

Mrs GOITCH and her brother are not in contact at the moment [redacted]

Mrs GOITCH has signed an authority for her mother's Haslar notes and has provided us with a copy of her mothers notes.

DOCUMENT RECORD PRINT

Officer's Report

Number: R7EP

TO:
STN/DEPT:

REF:

FROM: DETECTIVE CONSTABLE 424 ROBINSON
STN/DEPT: OPERATION ROCHESTER

REF:
TEL/EXT:

SUBJECT:

DATE: 11/10/2004

The Key Clinical Team met and discussed the following cases on Saturday 9th October 2004 (09/10/2004). All team members were present, Code A BJC/84 & JR/8 was marked as 2A. The individual marks are as follows: Code A 2A, Code A 2A, Code A 2A and Code A 2b.

Arthur COUSINS BJC/85 & JR/9 1A.

All teams members scored the same.

Christina TOWN BJC/86.

Noted that Code A never received any opiates but was prescribed 40-200mg Diamorphine. Because of this she is scored as a 2A. Individual scoring is as follows Code A=1A, Code A 2A, Code A 2A, Code A 2A.

HAMPSHIRE CONSTABULARY

CHRISTINA TOWN

BJC86 Christina Town

Date of Birth Code A **Age: 91**
Date of Admission to GWMH: 9th May 1996
Date and time of Death: Code A
Cause of Death:
Post Mortem: no
Length of Stay: Code A ***days***

Mrs Town's past medical history was noted to be:-

- Fractured hip after fall in 1993

Mrs Town had two daughters and lived with one of them. A home carer called daily to help Mrs Town with personal needs. She was a small frail lady who wore glasses for reading. She had a long-term catheter in place which required daily wash outs for which the district nurses attended to. Mrs Town was admitted to Sultan Ward of the Royal Haslar Hospital for respite care on 9th May 1996. She was transferred to Gosport War Memorial Hospital for long term stay on 31st May 1996.

Care plans commenced for hygiene, confused and frail, elimination, reddened area to sacrum and *settle at night.* (page 57 to 94) A *handling* profile on 7th September 1996 noted that Mrs Town's had poor communication, sometimes non-complaint, does not appear to be in pain, **nursed on pegasus airwave mattress, *she had 2 hourly turns and wears pads for incontinence.*** (page 81/82)
A **Barthel** ADL index (score 1) was completed weekly. (page 109/110)
A **Waterlow** was completed with a score of 29 noted. (page 107) A nutritional assessment was also completed on 26th May 1996 noting a score of 13. (page 106) An assessment of activities of daily living was completed noted that Code A Town **needed cot sides** (*why?*), had short term memory loss, irregular eating habits, *catheter in place that needed x2 weekly washouts* and that she was immobile and needed a wheelchair. (page 134)

Daily summary

9th May 1996
Summary of significant events – admitted to Sultan Ward for respite care. (page 96)
23rd May 1996
Summary – fell x 2 bump on left side of head. Small skin flap on leg numerous bruises. Sounds chesty. (page 96)
24th May 1996
Summary – seen by Code A for referral to Dr Lord ? long stay bed. (page 96)
31st May 1996

Clinical notes – transfer to Dryad ward. Immobile to make comfortable. **Happy for nursing staff to confirm death. Keep on regular medication.(WHY?)** (page 45)
Summary – transfer from Sultan ward to Daedalus already seen by Dr Bark.
Night – seems settled became restless and attempted to get out of bed. (page 96)
1st June 1996
Summary – **very aggressive** on being put to bed boarded for triclolos.(p116) (page 96)
3rd June 1996
Summary – seen by Dr Lord no changed in treatment. (page 97)
13th June 1996
Summary – recatheterised. (page 97)
14th June 1996
Summary – seen by Dr Barton antibiotics commenced as urine very offensive. (page 97)
17th June 1996
Clinical notes – catheterised pressure area intact. Continue NHS long stay. (page 46)
1st July 1996
Summary – seen by Dr Lord nil ordered. (page 97)
15th July 1996
Summary – referred to dentist. (page 97)
29th August 1996
Summary – fell from bed. (page 97)
30th August 1996
Clinical notes – fell out of bed. Bruising to back of head and right knee. Skin flap right arm. Neurological obs OK until today. (page 46)
Summary – seen and examined by Dr Barton bed rest today. Daughter informed of accident. (page 97)
5th September 1996
Summary – appears to have cold and chest infection. **Seen by Dr Barton who is *to see daughter.* She is happy to leave treatment up to us.** (page 97)
6th September 1996
Summary – both eyes inflamed bathed and eyes drops instilled. Complaining of headaches paracetamol given. 20.20 hours found on floor check for injures. Small laceration to right upper foot, cleaned with n/saline and bioclusive applied. Accident form completed. (page 97)
7th September 1996
*Clinical notes – **found on floor again.** New graze right foot. (page 46)*
Summary – seen by Dr Peters. (page 97)
9th September 1996
Clinical notes – **found on floor twice by nursing staff. ? climbs over cot sides ? crawls around cot side (was a problem at home). (page 46)***(should have taken cot sides down)*

Summary – seen by Dr Lord no change. (page 98)
14th September 1996
Summary – condition discussed with daughter was surprised her mother may not survive chest infection. Future treatment discussed and assured her mother would remain comfortable. (page 98)
18th September 1996
Summary – visited by daughter. Mrs Town showed us her right forearm. She cannot tell us how she did it obviously done it in last ½ an hour as still bleeding. No idea how and when she did it. Steristrips applied and accident form completed. (page 98)*(indicates very poor level of supervision)*
20th September 1996
Summary – sleepy today. (page 98)
23rd September 1996
Summary – seen by Dr Lord to remain in long stay bed. (page 98)
29th September 1996
Summary – marked deterioration. (page 98)
7th October 1996
Clinical notes – seen by doctor explained Mrs Town's is mentally and physically frail. Agreed not for IV or NG tube for antibiotics or fluids. Uncertain about treatment for future re chest infections. Agreed to keep Mrs Town comfortable. (page 47)
Summary – daughter seen by Dr Lord Mrs Town not for transfer to be made more comfortable if condition deteriorates further. (page 98)
11th October 1996
Summary – diet and fluid intake poor. (page 98)
23rd October 1996
Summary – found on floor beside bed assisted back to bed no apparent injuries. (page 98)
8th November 1999
Summary – appears to have had a TIA immediately put back to bed and obs noted. Dr Brookes duty doctor informed. Granddaughter informed as daughter on holiday. Remains pale to be observed. (page 99)
18th November 1996
Clinical notes – deteriorating in bed most of the day. Continue NHS continuing care. (page 47)
Summary – seen by Dr Lord PRN nebuliser prescribed. (page 99)
25th November 1996
Summary – deterioration continues. (page 99)
28th November 1996
Clinical notes – condition deteriorated during night breathing shallow limbs cyanosed. 01.30 hours death confirmed by SS/N Tubbritt witnessed by N/A M Gallagher and N/A K Wallington. Daughter informed. (page 47)
Summary – *01.20 hours contacted daughter eventually condition deteriorated* rapidly. 01.30 hours died. (page 99).

(Page 7) Diamorphine 40 mgms is a high dose. Bad prescription, undated, not administered.

Operation Rochester. Clinical Team's Assessment Form				
Care Death/Harm	Optimal 1	Sub Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A		2A		
Unclear B				
Unexplained by Illness				

Code A

DOCUMENT RECORD PRINT

Officer's Report

Number: R7EP

TO:
STN/DEPT:

REF:

FROM: DETECTIVE CONSTABLE 424 ROBINSON
STN/DEPT: OPERATION ROCHESTER

REF:
TEL/EXT:

SUBJECT:

DATE: 11/10/2004

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All teams members scored the same.

Christina TOWN BJC/86.

Noted that Mrs TOWN never received any opiates but was prescribed 40-200mg Diamorphine. Because of this she is scored as a 2A. Individual scoring is as follows A. Code A =1A, Code A 2A, Code A 2A, Code A 2A.

DOCUMENT RECORD PRINT

Officer's Report

Number: R7DC

TO:
STN/DEPT:

REF:

FROM: DETECTIVE CONSTABLE 424 ROBINSON
STN/DEPT: OPERATION ROCHESTER

REF:
TEL/EXT:

SUBJECT:

DATE: 28/04/2004

At 1400 hrs on Monday 23rd February 2004 (23/02/2004), I attended Code A Code A where I spoke with Mrs Margaret PETHERICK and her sister Mrs Pauline BENNETT , 2 Code A in relation to their mother Christina May TOWN Code A The sisters will say;

Christina TOWN nee CHESTER was born in West Yorkshire. She initially worked in a cotton mill on the looms and then went on to work in a shop.

She married her husband Henry Harrison TOWN in 1927 and together they had two daughters, Margaret and Pauline.

Christina ran a boarding house in West Yorkshire, she is described as being very hard working and suffered from a 'bad back'. She had an operation on her back when aged around 45/46 yrs.

In her early 60's Christina fell and gashed her leg, she was admitted to hospital for treatment. At this point she retired and went to live in Morcombe. She is described as being very independent.

Eventually she moved down to Gosport and lived with Pauline.

When in her early 90's, Christina fell and broke her hip, she received treatment at Haslar Hospital and was discharged to a nursing home. In the brief time that she was there she fell out of bed and broke the same hip again. At this point Christina, upon recovering, was discharged and returned to live with Pauline.

Around May 1996 Christina was admitted to the Gosport War Memorial Hospital for respite care. She had no illnesses and did not require any medication. She couldn't walk due to problems with her hip and the 2 breaks and required lifting.

It was suggested that Christina be admitted permanently to Sultan Ward and this offer was accepted by the family as Christina would have constant care and company. She was happy with this arrangement.

Christina was visited every other day by Pauline and was happy.

DOCUMENT RECORD PRINT

The family noticed that during the October Christina's memory became worse, she appeared slightly demented. She hurt her arm but couldn't remember how, when asked.

At some point during October '96 Margaret PETHERICK received a call from the ward telling her to "come quickly" as they didn't think her mother would last the night. She arrived within 1½ hrs to find her mother sitting up in bed cheerfully chatting and quite surprised by her daughter's unexpected visit.

Towards the end of October Christina appeared to be 'fading', towards the end of her life staff told the family that her body was 'closing down' and she wasn't fed but staff said that the family could feed her if they wanted to. She didn't eat but was given drinks, she appeared chirpy and alert.

Christina continued to fade and during the least week of her life is described as being "drugged up to the hilt" and became a "zombie".

During her time in the hospital she had never complained of any pain nor had she suffered from any other illnesses, cough or colds.

She was moved into a single room on the day before she died. The family didn't see any form of medication being administered but their mother appeared to be sleeping deeply as if drugged.

Christina died on 28th November 1996 (28/11/1996). The death certificate was signed by Jane BARTON and cause of death was given as Bronchopneumonia.

The family's concerns relate to the speed of Christina's demise and the lack of nourishment she received.

They say that she was a very strong woman physically, with a strong will and would 'lash out' at people. The family wonder if she caused problems for the staff who subsequently dealt with her inappropriately.

Mrs PETHERICK's phone number is Code A

HAMPSHIRE CONSTABULARY

ALFRED LEE

OPERATION ROCHESTER
CLINCAL TEAM'S SCREENING FOI

Code A

Patient Identification Lee, Alfred **Exhibit numl**

Care / Death/Harm	Optimal 1	Sub-Optimal 2	Negligent 3	Harm 4
Natural A				
Unclear B		√		
Unexplained By Illness C				

General Comments

7.5.96 transferred from QAH to Daedalus. Admitted by Dr Barton. Drug charts in the notes from that date do not show any new or altered drugs compared with before transfer. Was already on thioridazine 10mg TDS (aggressive demented man) but no prn thioridazine given.
Code A nursing notes say he has deteriorated overnight, cannot get him to take anything orally. S/D of D40mg, midazolam ?20mg and hyoscine ?200mcg (very poor photocopies) set up at 9.55am. Patient died at 17.45 that day. Further drug chart in notes showing fentanyl 25mcg and amitriptyline 25mg at night written up on 9.5.96 but none of these drugs were given. If fentanyl had been applied on 7.5.96, it would not have been due for changing till 10.5.96, suggesting that this was a new prescription (because he could not swallow) superseded by the S/D.
Underlying problems were COAD, dementia, deafness, some LVF, and intermittent vasovagal attacks which made him hypotensive and unresponsive but from which he had previously always made a full recovery. Not clear whether what happened on 8.5.96 was a vasovagal attack unrecognised by the nursing staff because they were unfamiliar with him. If so, if the S/D had not been set up he might have again recovered. But it might have been another problem, and he might not. Cannot really, on the scanty notes recorded, give any opinion as to the cause of death.
Did not have a good prognosis in view of multiple pathologies and the progressive nature of dementia. He was already doubly incontinent and transferring with two people, so he was well down the road of deterioration with dementia. But no indication from the QAH notes that he looked like dying at that point in time.

Final Score: 2B

Screeners Name: Code A
Date Of Screening: 26.5.05

Signature

13/6/05

BJC 91 (an 88 year old male, date of birth Code A

Transferred to Daedalus 7/5/96 from QAH
Admitted to QAH 2 months before with 5% burns to his perineum. Said to have a variable mental state. Had an indwelling urinary catheter and was faecally incontinent. He had also experienced short lasting episodes of unresponsiveness which were thought to be vasovagal episodes.

Within 2 days his condition had deteriorated. He was not taking medicines, fluid or diet. At 09.15 on 9/5/96 there was a conversation with his wife and it was agreed to make him comfortable (although I could find no record of him being in pain or distress). A syringe driver of diamorphine 40mg and midazolam was set up. About 8 hours later he died (ie about 13mg diamorphine which is not a large amount).

Code A

Grading 2B
2 because I could not find a clear indication for using the sc infusion and it was a high starting dose especially when his renal impairment is taken into account. however he was clearly unwell and the syringe driver appears to have followed an acknowledgement that his condition was terminal.
B because I could not find a clear cause for his death but I felt the contents of the infusion had probably not had long enough to significantly contribute to his death (at least the diamorphine although I suppose the midazolam could have had an effect)

DOCUMENT RECORD PRINT

Officer's Report

Number: R7EN

TO: REF:
STN/DEPT:

FROM: DETECTIVE CONSTABLE 424 ROBINSON REF:
STN/DEPT: OPERATION ROCHESTER TEL/EXT:

SUBJECT: DATE: 06/10/2004

I spoke with Mrs HUNTER at 1555 on 29/09/2004 in relation to Action 1236.

She told me that she had contacted the police in 2001. She believes she spoke to a female officer who told her that they (the police) would let the family know if 'they' found anything. She subsequently received a letter telling her of a meeting that was being held. She believes it was from Det Supt JAMES . She didn't attend this meeting and has heard nothing since.

Mrs HUNTER told me that her father was admitted to the QA Hospital with burns to his crotch area where he had spilt boiling water down his lap. He suffered from bronchitis and was 'steaming' himself at the time.

Whilst in the QA he had his 'ups and downs' had been depressed and suffered from hallucinations. His wounds were healing and he did require pain relief. She states that although her father had become thin and had 'gone downhill' he was 'not expected to die'. He was then transferred to the GWMH where he was visited on the next day by his wife who described him as being cold and that he had had an injection which had made him very drowsy. Mr LEE died the following day.

Mrs HUNTER doesn't know what her father died of but she states he didn't have dementia but he did have hallucinations.

Her brother, Terry LEE 7[Code A], was able to visit more often and she states that he was not concerned to [Code A]s treatment at the time.

Mrs HUNTER has a sister Sheila SHEPHERD , [Code A]

Mrs HUNTER is of the opinion that we have/are carrying out enquiries into her father's death.

HAMPSHIRE CONSTABULARY

EDITH HILL

BJC 92 (an 86 year old female, date of birth Code A

Transferred to Daedalus Ward 6/11/98.
Problems before transfer were breathlessness due to congestive cardiac failure (requiring high dose frusemide plus metolazone which is a combination reserved for poorly responsive CCF). A liver ultrasound suggested the presence of liver metastases.

On 14/11/98 she had very noisy breathing and was distressed. It sounds as though she had a combination of worsening CCF with bronchopneumonia. Antibiotics were continued and she was given intravenous frusemide with intravenous diamorphine (5mg) which is acceptable practice. Later that day a syringe driver was started with diamorphine and midazolam. She died about 14 hours after the syringe driver was started.

HILL

Grading 2A
2 because the starting dose of opiate in the driver was high although I think the use of opiate was not inappropriate (unless she was unconscious when it was started)

A because she had congestive heart failure and possibly bronchopneumonia and possibly a liver deposit, so she had enough natural causes for her death.

Code A

DOCUMENT RECORD PRINT

Officer's Report

Number: R7EO

TO: REF:
STN/DEPT:

FROM: DETECTIVE CONSTABLE 424 ROBINSON REF:
STN/DEPT: OPERATION ROCHESTER TEL/EXT:

SUBJECT: DATE: 01/10/2004

I visited Ann Christine HOLMES [Code A] at her home address [Code A] [Code A], in relation to her mother Edith Daisy HILL (nee KIDD) b.26/01/1912. Edith HILL was born in Wimbledon, Merton and was the second eldest of four children. Her two brothers died in their 60-s - 70's from cancer and her sister died after her, again of cancer.

Edith worked as a secretary up until her marriage to Percy James William HILL in 1936 when the couple moved to the Portsmouth and Gosport areas, where they remained. They had two children, James Anthony (known as Tony) [Code A] and Ann .

Edith is described as being generally healthy and fit. She became a widow in 1995. She was admitted to hospital aged around 60-70 with shingles in her eye.

She received treatment and returned home to her bungalow at [Code A].

In 1996 she fell and was admitted to Haslar Hospital . Mrs HOLMES believes that this was in order to determine why she fell. She was not admitted due to any injury sustained.

She returned home and lived alone with the aid of a 'home help'.

At one stage she was assessed for a hysterectomy and Mrs HOLMES took her to the Queen Alexandra Hospital to see if she was suitable for surgery.

It was at this time that the consultant thought that Edith had a heart murmur and he was going to arrange an ECT scan. This was never carried out as in the September/October of the year (1998) Mrs HILL again fell whilst at home and was admitted to Haslar Hospital for tests.

Mrs HOLMES was out of the country residing in America and her recollections of events are vague.

She believes that her mother was diagnosed with heart failure and as having an enlarged liver. She also had swollen legs.

Mrs HILL, whilst still at Haslar, was taken home by [Code A] and the Social Services to see if she was able to cope on her own. This was not a residential stay but a quick visit. It was very soon apparent that

she was not able to live alone and she returned to Haslar and was then sent to the Gosport War Memorial Hospital for assessment as to her needs.

Mrs HOLMES believes that her mother was in the GWMH for several weeks undergoing assessment.

Mrs HOLMES flew back to visit her mother on (she believes) Tuesday 12th November 1998 (12/11/1998) and visited her mother at the GWMH on Wednesday 13th November 1998 (13/11/1998).

She describes her mother as being cheerful, happy to see her, lucid. She had just been to the hairdressers and looked happy and content.

As the visit progressed Mrs HILL complained of feeling hot and sweaty. She asked to use the toilet and Mrs HOLMES went to get a member of staff to help her mother.

She states that the nurses were sat at the nurses station drinking tea and they told her that they would come to assist her mother when they had finished.

When it came to meal time, Mrs HOLMES took her mother into the dining room and sat her at a table where upon Mrs HILL complained of feeling sick.

Mrs HOLMES informed a member of staff who told her to take her mother away from the meal table as she could upset the other patients if she was sick.

Mrs HILL was sweaty and feeling sick and Mrs HOLMES asked a nurse to check her mother. The nurse took her mother's pulse and said that the doctor would look at her the next day.

The following day - Thursday 14th November 1998 (14/11/1998) Mrs HOLMES received a phone call from a member of staff from the hospital informing her that her mother was worse and could she come in and see her. They also asked if they could give her something 'for the pain'. Mrs HOLMES does not recall being spoken to about Diamorphine but she was aware that was given to her father when he was in pain when he died in 1995.

Mrs HOLMES went to the hospital and found her mother had been moved to a single room where she was on her own. She describes her as being unconscious.

Mrs HOLMES was spoken to by a male doctor. She enquired as to her mother being moved to a hospital which could treat her and was told that her mother would die in the ambulance or in a busy ward with other people and that it would be better if she died in the GWMH in peace.

Mrs HOLMES felt that the doctor was uncaring and had 'written her mother off' because of her age. She thought him to be unsympathetic with a poor bedside manner.

Mrs HOLMES stayed with her mother who remained unconscious with the exception of one occasion when she opened her eyes and said "It hurts, it hurts". There was no conversation.

Mrs HOLMES didn't see a syringe driver but she describes her mother as being completely out of it. She looked gaunt and appeared years older, a marked contrast to the previous day. She sounded chesty as she breathed.

DOCUMENT RECORD PRINT

Mrs HOLMES and her brother remained with their mother until she died the following morning.

Mrs HOLMES concerns are that the nurses didn't act promptly when her mother was hot, sweaty and feeling sick. She believes that these were the first symptoms of a heart attack and could have been treated.

That she wasn't sent for treatment, she was considered old and expendable.

When Mrs HOLMES father died he was very sick, her mother wasn't.

Mrs HILL was cremated at Portchester Crematorium.

The cause of death is given as 1(a) Bronchopneumonia, (b) Congestive cardiac failure, (c) Aortic stenosis and was certified by E J PETERS .

Mrs HOLMES was living in America at the time but has since returned to the UK.

She states that her brother-in-law, Peter HOLMES Code A Code A visited her mother whilst she was in Haslar but he didn't see her in the GWMH.

Mrs HOLMES says that after her mother had died a nurse 'rushed in' to the room and collected her mother's notes then rushed out again, which she felt was a little odd.

Mrs HOLMES has provided a copy of her mother's death certificate which I have enclosed.

I have obtained an authority for Haslar and am in the process of raising Edith HILL's medical records.

JEAN STEVENS

JEAN STEVENS

BJC/46 Jean Stevens

Date of Birth: Code A Age: **73**
Date of admission to GWMH: **20th May 1999**
Date and time of Death: **22.30 hours on 22nd May 1999**
Cause of Death:
Post Mortem: **Burial**
Length of Stay: **2 days**

Mrs Stevens past medical history:-

IHD
MI x 2
COPD
Sigmoid resection due to diverticulitis and stricture
Asthma
Pneumonia
Arthritis

Mrs Stevens lived with her husband and had 2 daughters. They managed all their needs and were independent. Mrs Stevens suffered a CVA and was admitted to the Royal Haslar Hospital on 26th April 1999 her recovery was affected when she suffered a Myocardial Infarction on 28th April 1999. Mrs Stevens was transferred to the Gosport War Memorial Hospital on 20th May 1999. She was catheterized, had an NG tube feed and her pressure areas were intact except for a very sore groin area.

On admission an assessment for was completed noting that she had poor hearing in right ear, poor vision wears glasses all the time, her speech was slow and slurred, was complaining of abdominal pain due to bowel problem. Care plans commenced for catheter, personal hygiene, shoulder pain, pressure area care, poor gag reflex, and night care.
Waterlow score 25 was recorded, a Barthel ADL index scored 1.
An abbreviated mental study was completed scoring 4.

A handling profile was completed noting that Mrs Stevens had abdominal pain, skin dry and intact, nursed on pressure relieving mattress and a catheter and NG feeding tube were in place.
A nutritional assessment was completed noting a score of 20.

20th May 1999

Transfer form notes Mrs Stevens has suffered a right CVA dense left hemiplegia unresolved, recovery affected by MI on 28th April 1999 now remains dense left hemiplegia with no swallow, catheterized and faecally incontinent, needs all care, NG feeding, pressure areas intact though very sore groin area.
Clinical notes – transferred needs all help, transfers with hoist. Barthel 0.
Summary – transferred from A6 Haslar. NG feed required due to poor gag reflex. Speech slurred. Alert and aware of surroundings.

21st May 1999

Contact record – AM regular 4 hourly oramorph 10mgs. PM uncomfortable throughout afternoon despite 4 hourly oramorph.
Husband seen and very upset.
Agreed to commence syringe driver for pain relief at equivalent dose to oral morphine with medazolam aware of poor outlook but anxious that medication given should not shorten her life. 19.45 commence syringe driver 20mgs diamorphine and midazolam in 24 hours.

22nd May 1999

Summary – condition deteriorated very bubbly 20mgs diamorphine syringe driver. 22.30 died one daughter contacted. Police contacted to try and notify other daughter
Clinical notes – died peacefully at 22.30 hours husband present. For burial.
Verified by SSN Tubbritt.

Code A

Code A

BJC/46
JEAN STEVENS
73

Stroke with marked weakness of left side complicated by a myocardial infarction and aspiration pneumonia. On day of transfer had suffered chest pain all day but had not told anyone (page 24). A strange decision was made to stop her prophylactic anti-anginal treatment and use GTN as required and oramorph. She was reported to be uncomfortable on the day of conversion to diamorphine via syringe driver. She then deteriorated rapidly. The pain was likely to be cardiac and I think they should have tried specific angina treatment before resorting to regular opiates. Angina after a myocardial infarction has a poor prognosis especially in someone who has other severe problems. However I think the use of opiates was overdone.

PL grading A2

BJC/46 new files JR/04
JEAN STEVENS
73

I could not find anything to help here except for use of prn cocodamol and diamorphine which makes the opiate use in GWMH seem less excessive.

Not graded for these notes
Overall group grade 2B

BJC/46	Stevens, Jean N3/3	Severe IHD and consequent dense left hemiparesis with no recovery. NG feeding; had already survived 1 episode of aspiration pneumonia. Poor prognosis. Admitted to GWMH; only recorded pain in transfer letter was skin discomfort in groin, responding to Sudocreme (pain not mentioned in admission clerking). On admission, begun immediately on morphine 5mg PRN – but given regularly – then changed the next morning to 10mg 4 hourly. Syringe driver set up the same evening, and died Code A I can see no evidence that local measures or simple analgesia were used to reduce discomfort – cream to skin and regular paracetamol would have been suitable management for this lady. I find it hard to believe other than that the morphine materially hastened her death.	B3
JR/04	Stevens, Jean N3/3	These are the Haslar notes which include the final admission. They reveal a more major pain problem than had been apparent from the GWMH notes. She had multiple episodes of surgery for diverticular disease, complicated by anastomotic leak and abscesses, then anastomotic stricture. She was left with chronic pain in the LIF for which she took codydramol (although she had been advised to use diclofenac instead in view of the constipating nature of codydramol). She had been referred to the Pain Clinic in March 1999, but was not seen before she had her final stroke. During her Haslar admission following the stroke and MI, she took regular codydramol and PRN doses of diamorphine 5mg SC (I think 2.5mg would have been more appropriate, given her background medication). But seems never to have taken more than 2 doses in 24 hours and on several days to have taken none at all. So I stand by the original conclusion that the regular opioid prescribed in GWMH was inappropriate and unnecessary, and may have hastened her death, although her prognosis was already very poor. I note there may also have been some confusion about the purpose of going to GWMH. Code A 's assessment letter refers to a "slow stream stroke care" bed, but the transfer letter in the Haslar notes refers to "going for rehab" – which was not in fact what was being offered but may have been the words used to the family.	1A

Officer's Report

Number: R7CF

TO:
STN/DEPT:

REF:

FROM: DETECTIVE CONSTABLE 424 ROBINSON
STN/DEPT: OPERATION ROCHESTER

REF:
TEL/EXT:

SUBJECT:

DATE: 02/03/2004

With reference to the meeting held by the clinical team on 29th February 2004 (29/02/2004) the following categories were given to the outstanding patients.

BJC/46 + JR/4 **STEVENS** N313 After reviewing the Haslar notes the team placed Mrs STEVENS as a 2B. They noted she had been receiving an escalating dose of diamorphine whilst at Haslar. Jean STEVENS was originally categorised as a 3.

DOCUMENT RECORD PRINT

Officer's Report

Number: R7CF

TO:
STN/DEPT:

REF:

FROM: DETECTIVE CONSTABLE 424 ROBINSON
STN/DEPT: OPERATION ROCHESTER

REF:
TEL/EXT:

SUBJECT:

DATE: 02/03/2004

With reference to the meeting held by the clinical team on 29th February 2004 (29/02/2004) the following categories were given to the outstanding patients.

BJC/7 + JR/3/KMR/1 CARBY With the review of the requested Haslar notes no change in the original category was given.

BJC/22 + JR/1 HADLEY With the review of the requested Haslar notes, no change in the original category.

BJC/46 + JR/2 ROGERS With the review of the requested Haslar notes, no change in the original category.

BJC/76 with the review of the correct set of notes relating to John RITCHIE . The team was unable to give any opinion as the records only related to a period between 1976 - 1981 . I have spoken to the records staff at GWMH and they are reviewing their search.

BJC/39 + JR/5 RAMSEY After reviewing the correct notes for Joan RAMSEY, she was placed in the 1A category.

BJC/46 + JR/4 STEVENS After reviewing the Haslar notes the team placed Mrs STEVENS as a 2B. They noted she had been receiving an escalating dose of diamorphine whilst at Haslar. Jean STEVENS was originally categorised as a 3.

BJC/58 + JR/6 CORKE The team didn't feel that this patient fell within the remit of Operation Rochester. However they did feel that the GP management was poor/negligent. They marked this case as a 2A, when I requested a score based on the information available to them.

In relation to the additional cases supplied by the police the following applies.

BJC/59 COX Mary : 1B

BJC/77 CLEMENTS : 2B. I enquired if the quality of these notes made them legible, I was informed they were. The hard copy supplied by WORM is of poor quality.

DOCUMENT RECORD PRINT

BJC/78 DONOGHUE : 1A. In the absence of the drugs charts but going on entries in the nursing notes the team were able to mark this patient.

BJC/79 + JR/7 SMITH Horace With reference to the requested Haslar notes, Mr SMITH was placed within the 1A category. He was initially placed as a 2 due to lack of information at the time.

BJC/80 BRENNAN : 1A noted that her daughter treated her. Her date of death is incorrect on the file.

BJC/81 BENSON : 2a

BJC/82 CRESDEE Olive : In the absence of any medical notes, nursing notes or drugs charts the team were unable to allocate any category.

BJC/83 HURNELL The team felt that there were problems with this lady's treatment but felt they were outside the remit of Rochester. They noted that the family had received an apology from the PHCT. This patient was sent to a psychiatric hospital as there were no beds at the hospice despite the family requesting she be returned to an acute ward. See O/R relating to HURNELL ref 'comments on finding'.

In relation to the records relating to Professor BAKER's report the following was concluded.

BJC/60 STANFORD Dorothy : 2B

BJC/61 WILLIS Norman : 2A

BJC/62 BURT Margaret : 2A

BJC/63 HORN Frank : 2B

BJC/64 MILLER Vera : 2A

BJC/65 ASKEW Catherina : 2B

BJC/66 HORNE Phyliss : 2B

BJC/67 LAKE Ruby : No score due to absence of drugs charts, nursing notes and Haslar notes.

BJC/68 LEEK Mable : 2B comments made about doses of opiates being made late at night, why?

BJC/69 SKEENS Euphemia : 2A

BJC/70 MARSHALL Rhoda : 2B

BJC/71 PITTOCK Leslie : 3B Dr NAYSMITH marked this case a '3C'. It gave the team a huge amount of concern.

BJC/72 SERVICE Helena : 3B

DOCUMENT RECORD PRINT

BJC/73 BROWN Pamela : 2B concerns due to huge increase in dose of medication.

BJC/74 DUMBLETON Harry : Unable to access accurately due to lack of drugs chart. This case caused "high concern", suggested checking drug register for sequence of events relating to 07/06/1993 - 11/06/1993 where in nursing notes refers to sedated but concerns as to 'what with'.

BJC/75 HARRINGTON Wilfred : 2A

BJC/76 RITCHIE (see previous note)

BJC/77 CLEMENTS Doris : 2B medical team notes legible but WORM copy poor.

I have made enquiries with ref to Gladis RICHARD with Janice RIX at Royal Naval Institute of Medicine (Code A). She will raise the records relating to RICHARDS and if the required authorities are in place, release the originals. If not then she will allow access to document at the institute. I await her call upon finding them. I have updated GWMH in relation to RITCHIE they are making further searches for any other files relating to John RITCHIE.

The medical team pointed out that some records relating to BJC/70 + BJC/72 had been mixed up between both sets on the DVD/CD.

RESTRICTED

Statement number: S211

DOCUMENT RECORD PRINT

STATEMENT PRINT

Surname: STEVENS

Forenames: ERNEST JOHN

Age: 77 Date of Birth: Code A

Address: Code A

Occupation: RETIRED AMBULANCE DRIVER

Telephone No.: Code A

Statement Date: 16/04/2004

Appearance Code: Height: 1.73 Build:

Hair Details: Position Style Colour

Eyes: / Complexion: /

Glasses: Use:

Accent Details: General Specific Qualifier

Number of Pages:

I live at the address known to the Police. I am the widower of Jean Irene STEVENS , who died on Code A at the Gosport War Memorial Hospital , Bury Rd, Gosport. I have been asked to provide some background information about my wife.

My wife was born on Code A in Gosport, Hampshire. Her parents were Harry and Eleanor Victoria COLLINGS . She was one of five children, all girls. Two of her sisters died in their teens due something like diphtheria or T.B. and her other sisters, Lillian and Iris died around the age of 70 years and 80 years.

Harry COLLINS died around the age of 79 years of bronchial pneumonia and Eleanor died around the age of 69 years from lung cancer.

My wife worked throughout her life as a shop assistant or canteen assistant.

We had two children, Carol in 1946 and June in 1949. Both pregnancies were straightforward with no complications.

My wife was relatively healthy but in 1994 she began to experience stomach trouble, she was experiencing a lot of pain and discomfort.

She was admitted to Haslar Hospital in Gosport for an exploratory operation, during which they removed her appendix. The problem persisted and in 1996 she was again admitted to Haslar where she was diagnosed as suffering from diverticulitis. She underwent surgery and had a small part of her bowel removed.

She went on to have two further operations on her bowel. Apparently she had lesions in her bowel due to the operations and it was this that was causing her pain.

As a result of this my wife was in constant pain and was prescribed pain killers.
She also suffered from slight arthritis in her back, but despite this, she was fully mobile and able to get about without assistance.

On Sunday 25th April 1999 (25/04/1999) we spent the day at home. Jean had cooked a roast dinner and tidied everything away as usual. We had our usual night cap before Jean went to get ready for bed.

I heard a thud and went to see what had happened, I found Jean lying semi conscious in the bathroom . I called an ambulance and Jean was taken to Haslar Hospital in the early hours of Monday 26th April.

By visiting hours that evening Jean was propped up in bed fully conscious. She had lost the use of her left arm and leg but was fully alert and able to speak.
She had lost the ability to swallow and was being fed through a tube. She had to learn to swallow again in order to be moved to a rehabilitation ward before she could come home.

At one point it was thought that Jean had suffered a small heart attack and she was admitted into the CCU (coronary care unit) at Haslar overnight as a precaution. There were no other attacks and Jean only spent one night in the unit.

I spent everyday with Jean and I could see her getting better. The stroke had only effected her left side.

Jean made very good progress and was reviewed by a Dr. LORD , from the Gosport War Memorial Hospital. Dr LORD said that Jean had a sufficient enough swallow for her to accept her on to the rehabilitation ward at the Gosport War Memorial hospital. It was arranged that Jean would be transferred to the Gosport War Memorial hospital on Thursday 20th May 1999 (20/05/1999).

During the evening of Wednesday 19th May 1999 (19/05/1999), Jean was visited by June and her husband Ted . I had spent the day with Jean as usual and June had come in after she had finished work.

We were all in good spirits as Jean was moving towards coming home. We were planning a big family party for when she came out of the War Memorial hospital.
I left Jean happy and in good spirits. I was told that Jean would be transferred to Deadalus ward around lunch time the following day and that I should visit her at the Gosport War Memorial Hospital after 1pm (1300 hrs).

At 1.30pm (1330hrs) on Thursday 20th May 1999 (20/05/1999) I arrived at the ward. had to wait to see Jean as the nurse said that they were settling her in.

I was shown into a cubicle opposite the nurses desk, Saw that Jean was lying in bed with her eyes closed. I would describe her as being in a coma. She did not move , she did not speak, she did not respond in anyway to my being there. I was stunned by her condition.

I stayed with Jean all night, I sat next to her bed and held her hand.
I did not know what was going on or why Jean had deteriorated so quickly. No one came and told me what was happening. I was totally shocked and distraught.

I could hear the noise of a machine coming from Jeans bed and I could smell a sickly smell. I used to work as an ambulance man and I recognised the smell as being morphine.

On Friday 21st May 1999 (21/05/1999), at some point during the afternoon, I was approached by a man called Phillip . He was a charge nurse or 'sister' on the ward. He said to me something along the lines of 'your wife is in a lot of pain, can we have your permission to double her morphine?'

I felt very confused and upset , I did not understand what was happening but I was very concerned for my wife's well being. I thought that if the staff thought my wife was in pain then they knew best. I gave my 'permission' to Phillip for my wife's morphine to be increased.

He told me that he would phone Dr. BARTON for her permission to increase the dose.

Around 8.30pm (2030hrs) on Saturday 22nd May 1999 (22/05/1999) Jean died.

From the time I saw her at the Gosport War Memorial Hospital, I only saw her open her eyes once.

I never heard her make any sound at all, nor did I see her give any physical indication that she was in pain or discomfort.

I know that my wife had a syringe driver , I saw the tube going into her stomach and I could hear the sound of its motor.

After Jean died the driver was still going and I asked the staff to switch it off after about half an hour as I could not stand the sound of it.

Jeans death certificate gives her cause of death as Cerebrovasculer accident, which I understand to be a stroke.

Her death certificate was signed by Dr. BARTON.

My wife is buried at Ann Hill Cemetery, Gosport.

Whilst Jean was at the Gosport War Memorial Hospital, I never saw or spoke to any doctors and the only person who spoke to me about my wife's condition was the male nurse Phillip on that one occasion.

Signed: Code A *Signature witnessed by:*

RESTRICTED

Statement number: S211A

DOCUMENT RECORD PRINT

STATEMENT PRINT

Surname: STEVENS

Forenames: ERNEST JOHN

Age: 77 Date of Birth: Code A

Address: Code A

Occupation: RETIRED

Telephone No.: Code A

Statement Date: 16/04/2004

Appearance Code: Height: 1.73 Build:

Hair Details: Position Style Colour

Eyes: / Complexion: /

Glasses: Use:

Accent Details: General Specific Qualifier

Number of Pages: 1

Further to my statement dated 16th April 2004 (16/04/2004) I wish to add the following:

Jean had her operation to have her appendix removed sometime in the late 1970's and not 1994 as stated in my previous statement.

Signed: Code A Signature witnessed by:

RESTRICTED

Statement number: S209

DOCUMENT RECORD PRINT

STATEMENT PRINT

Surname: BAILEY

Forenames: JUNE MARY

Age: 54 Date of Birth: Code A

Address: Code A

Occupation: CLEANER

Telephone No.: Code A

Statement Date: 16/04/2004

Appearance Code: Height: 1.53 Build:

Hair Details: Position Style Colour

Eyes: / Complexion: /

Glasses: Use:

Accent Details: General Specific Qualifier

Number of Pages:

I live at the address known to the Police. I have been married to Edward BAILEY for the past 37 years.

I am the daughter of Ernest and Jean STEVENS . My Dad is still alive and my Mum died at the Gosport War Memorial Hospital on Code A

I have been asked if I can remember the events leading up to my Mum's death.

On Sunday 25th April 1999 (25/04/1999) my Mum had a stroke, she was taken to Haslar Hospital in Gosport . By the following evening she was propped up in bed and chatting away happily. She had

lost the use of her left arm and leg but she was able to talk as before and she still had all her faculties.

My Mum continued to get better and arrangements were made for Mum to be transferred to the Gosport War Memorial Hospital to the stroke ward.

She was due to be moved on Thursday 20th May 1999 (20/05/1999) and I visited her on the Wednesday evening. Dad and Ted were there and Mum was in good spirits. We were all laughing and joking and planning a big family party for when Mum came home. Mum and I were talking about perming her hair and she was talking to Ted about her garden. You would never have known that Mum had suffered a stroke to look at her, she looked so well. Her skin had a lovely colour and she was so happy and cheerful.

I left her around 9.30pm (2130hrs) and my last words to her were 'the next time I see you it will be at the War Memorial'

Around 6pm (1800hrs) on Thursday 20th May1999 (20/05/1999), I went to Daedalus ward at the Gosport War Memorial Hospital. I walked along the corridor with my Dad and walked past a single room where an elderly lady was sleeping. I carried on walking but my Dad called me back. He took me into the room where the old lady was asleep. I was totally stunned, this woman was my Mum. She was totally unrecognisable as the woman I had said goodbye to the night before.

Her eyes were closed and she appeared to be in a coma. I took hold of her hand but she didn't react. I could hear the sound of a machine working .It sounded so loud as the room was very quiet. I looked underneath my Mums bedclothes and I saw a machine lying on her stomach. Throughout my visit I didn't hear or see anything which would indicate that my Mum was in any pain. She never made a sound or movement at all.

Around 6pm (1800hrs) on Friday 21st May 1999 (21/05/1999), I visited my Mum with Ted My Dad was there as always.

I talked to my Mum and held her hand. She didn't respond in anyway. We left around 10 pm (2200hrs).

During the morning of Saturday 22nd May 1999 (22/05/1999), I received a telephone call for a man who identified himself to me as 'Phillip from the War Memorial' he asked me if I could come over straight away as my Mum was deteriorating.

Between 1-130pm (1300-1330hrs) I arrived at the hospital with my son Steven . The male nurse Phillip, took us in to a room. He told us that my Mum was deteriorating. Steven asked him if the move from Haslar Hospital had put Mum into a coma and Phillip replied that it didn't help her.

I was very upset and crying, I went into see my Mum. Dad was sat holding her hand. I stayed with my Mum until about 10 pm (2200 hrs) during the entire visit she never moved or displayed any emotion.

I was taken home by my daughter Susan , and had only been indoors for a few minutes when the hospital rang to say that my Mum had died.

I went straight back to the hospital and saw my Mum, I remember that I could still hear the sound of the motor of the pump.

I have been asked if I was spoken to by any member of the hospital staff in relation to the treatment of my Mum .I was never informed of anything apart from when Phillip spoke to me on the telephone and later in his office about my Mum getting worse.

Signed: Code A

Signature witnessed by: Code A

RESTRICTED

Statement number: S210

DOCUMENT RECORD PRINT

STATEMENT PRINT

Surname: BAILEY

Forenames: EDWARD KENNETH

Age: 56 Date of Birth: Code A

Address: Code A

Occupation:

Telephone No.: Code A

Statement Date: 17/04/2004

Appearance Code: Height: 1.68 Build:

Hair Details: Position Style Colour

Eyes: / Complexion: /

Glasses: Use:

Accent Details: General Specific Qualifier

Number of Pages:

I live at the address known to the Police and I am married to June BAILEY, nee STEVENS .

I married June in 1969 and knew her mother Jean STEVENS for some 39 years prior to her death in 1999.

I have been asked if I can recall any of the events that took place whilst Jean was in hospital just before she died on 22nd May 1999 (22/05/1999).

I remember that Jean had a stroke on Sunday 25th April 1999 (25/04/1999), it happened late at night and Ernie , her husband rang me the next morning to tell us what had happened.

Code A was taken to Haslar Hospital in Gosport and June and I visited her that Monday evening (26/04/99) (26/04/1999).

The first thing that Jean wanted to know was had I had my dinner. She was fully lucid and in good spirits. She had lost the use in her left arm and leg but apart from that you wouldn't know that there was anything wrong with her.

I remember that she gave me an unused specimen bottle that she had put by for me, she thought that I could use it to keep my screws in it, in my shed.

I saw Jean on Wednesday 19th May. I took June into visit after she had finished work, so this would have been around 6pm (1800hrs).

June had rushed in from work and hadn't had a chance to have a drink so I took her off for a coffee shortly after we got to the hospital. Jean made a comment that we weren't staying long. That evening we chatted about having a big party when she came home. It was not the sort of conversation you have to cheer some one up, we were all looking forward to Jean coming home.

I remember that it was a warm evening and Jean asked me to get her a damp tissue to mop her face with. She sent me back to the sink 8 times before it was cold enough for her. The whole visit was spent laughing and joking.

On Thursday 20th May 1999 (20/05/1999), Jean was due to be moved to the Gosport War Memorial Hospital for rehabilitation in the stroke ward.

On Friday 21st May 1999 (21/05/1999) I took June to visit Jean at the War Memorial Hospital. I was shocked at the condition of her. She was lying motionless in bed. I was so upset I cried. I took her hand and there was no response, at one point she opened her eyes but there was no recognition in them or any emotion.

I could hear the sound of a whirring motor and I could smell a horrible smell. I asked Code A what it was and he told me it was the smell of morphine.

That was the last time I saw Jean alive.

Signed:

Signature witnessed by:

GLADYS RICHARDS

Gladys Richards
Date of Birth: Code A Age: **91**
Date of admission to GWMH: **17th August 1998**
Date and time of Death: **21.20 hours on 22nd August 1998**
Cause of Death:
Post Mortem: **Cremation**
Length of Stay: **days**

Mrs Richards past medical history:-
Deaf in both ears
Cataract operation in both eyes
Six month history of falls
Alzheimers
Hysterectomy

Mrs Richards was a widow and had two daughters. She lived at Glen Heathers Nursing Home. Mrs Richards was allergic to eggs and mackeral. On 30th July 1998 Mrs Richards suffered a fall at the home and fractured her right neck of femur. She was admitted to the Royal Haslar Hospital and underwent a closed relocation of her right hip (hemiarthroplasty) with a canvas knee immobilising splint to discourage any further dislocation and to stay in place for 4 weeks. Mrs Richards was transferred to the Gosport War Memorial Hospital on 11th August 1998 for continuing care.
Mrs Richards was transferred to the accident and emergency department of the Royal Haslar Hospital on 14th August 1998 for reduction of dislocated right hip and was readmitted to the Gosport War Memorial Hospital on 17th August 1998.

On admission care plans commenced for sleep, nutrition, constipation and hygiene.
A Waterlow score of 27 was recorded on 11th August 1998 as well as a Barthel ADL index with a score of 3.

11th August 1998

Clinical notes – transferred to Daedulus ward after hemiarthroplasty. Catheter insitu and canvas knee immobilising splint to discourage further dislocation must stay in place for 4 weeks. On examination frail dementing lady. Not obviously in pain. Please make comfortable. Transfers with hoist. Usually routine, needs help with Activities of Daily living. **Happy for nursing staff to confirm death.**

Summary – admitted from E6 Royal Haslar Hospital for continuing care.

13th August 1998

Contact record – found on floor at 13.30 hours no apparent injuries. 19.30 pain right hip internally rotated.

14th August 1998

Clinical notes – sedation/pain relief has been a problem not controlled by haloperidol but very sensitive to oramorph.

Right hip shorter and internally rotated. Is she well enough for another surgical procedure? Daughter aware and not happy.

Contact record – hip x-rayed dislocated. Daughter seen by Dr Barton for transfer to Haslar accident and emergency department for reduction under sedation.

Transfer to Haslar Hospital for reduction of dislocated right hip.

Contact record – notified that reduction had been done and to stay at Haslar for 48 hours then return to Gosport War Memorial Hospital.

17th August 1998

Clinical notes – transfer to back to Daedulus ward. Readmission from Haslar after reduction under IV sedation. Remained unresponsive for several hours. Now appears peaceful.

Plan: - Haloperidol

-only give oramorph in severe pain.

- see daughter again

Contact record – returned to Gosport War Memorial Hospital very distressed and in pain. To remain in straight knee split for 4 weeks. Two pillows between legs at night. MRSA negative.

In pain and distress daughters agree oramorph 2.5mgs.

X-ray no dislocation seen. For pain control overnight.

18th August1998

Clinical notes – still in great pain. Suggest S/C diamorphine/haloperidol and midazolam. Please make comfortable.

Summary – reviewed by Dr Barton for pain control via syringe driver.

Daughters agreed to use syringe driver. Syringe driver 40mgs diamorphine , Haloperidol 5mgms and Medazelam 20 mgms commenced.

Peaceful reacted to pain when being moved.

Daughter upset and angry about mothers condition but happy pain free.

Stayed overnight.

Still unhappy with various aspects of care complaint to be handled officially.

21st August 1998

Clinical notes – much more peaceful. Condition very poor.

Pronounced dead at 21.20 by S/N Griffin. Relatives present. For cremation.

Summary – condition deteriorating.

Code A

BJC/41
GLADYS RICHARDS
91

This lady had a fractured neck of femur replaced with a hemiarthroplasty. This dislocated and she needed a further operation. There was pre-existing Alzheimer's. On return to GWMH she had pain treated with oramorph as required. She then developed severe pain and required a regular background of analgesia via syringe driver. The starting dose of 40mg seems excessive but her opiate requirement had increased considerably in the 15 hours before the driver was started and the dose is probably acceptable. I do not consider the opiates to be implicated in her death. The standard of care probably sub-optimal eg fall out of chair leading to dislocation.

PL grading A2

Expert Review

Gladys Richards

No. BJC/41

Date of Birth: Code A

Date of Death: 22 August 1998

On 30 July 1998 Mrs Richards suffered a fall at the Glenheathers Nursing Home where she lived. She fractured her right neck and femur and was admitted to the Royal Haslar Hospital where she underwent a closed relocation of her right hip.

She was transferred to the Gosport War Memorial Hospital on 11 August 1998 for continuing care. She was readmitted to the Royal Haslar Hospital on 14 August 1998 for a reduction of her dislocated right hip and was readmitted to Gosport War Memorial Hospital on 17 August 1998. Plan on admission was to continue Haloperidol and only to give Oramorph in severe pain.

Mrs Richards, on the 18 August, was still noted to be in great pain at which point it was proposed that she was started on subcutaneous Diamorphine/Haloperidol/Midazolam.

Mrs Richards was noted to be much more peaceful on 21 August although her condition was noted to be very poor.

There is criticism made that the starting dose of 40mgs Diamorphine seemed excessive when starting the syringe driver but it was noted that Mrs Richards opiate requirement had increased considerably in the fifteen hours before the driver was started. Code A considered that the opiates were not considered to be implicated in her death. Code A felt the Diamorphine dose was too high and probably shortened her life but she seemed "unlikely to survive unless she had been left in severe pain (screaming)".[GR1]

[GR1] I have not seen an officer's report from the family in this case.

RESTRICTED

Statement number: S4A

DOCUMENT RECORD PRINT

STATEMENT PRINT

Surname: MACKENZIE

Forenames: GILLIAN M

Age: O.21 Date of Birth:

Address:

Postcode:

Occupation:

Telephone No.:

Statement Date: 27/04/1999

Appearance Code: 1 Height: 1.68 Build:

Hair Details: Position Style Colour

Eyes: / Complexion: /

Glasses: Use:

Accent Details: General Specific Qualifier

Number of Pages:

On the 26th September 1998 (26/09/1998) I received a copy of a letter dated 22nd September from the Portsmouth Healthcare Trust. I telephoned my sister Mrs L F LACK of Code A for her reaction. She did not agree with various paragraphs of the letter in particular that paragraph 7 and paragraph 8E and para 4 were not true. These paragraphs refer to Dr BARTON at the Gosport War Memorial Hospital . During that sam_ conversation she also mentioned the irregularities concerning my mothers death certificate, this was not only the certificate itself which gave the cause of death as pneumonia but also ? behaviour of the registrar when she registered th_ death. My sister had not had sight of the certificate prior to it being shown her at the registrars. She queried the cause immediatel_ as being the sole cause of death, particular_ as there had been no indication whatsoever of pneumonia. My sister has 40 years nursing experience with geriatric and terminally ill patients.

I told my sister I would not let this matter rest and on Sunday 27th September I telephoned Gosp_ Police Station.

Prior to phoning the police my sister had also told me that upon querying the cause of death with the registrar she said words to the effect of "I did not hear that, if I did hear that I would have to order a post mortem". My sister being in an emotional state burst into tears and said "I do not want anything else to happen to mother".

Referring back to my telephone call to Gosport Police Station, I spoke to DC Code A . I requested an appointment with an appropriate officer to make a report of unlawful killing in relation to my mother. I gave a good deal of detail to DC Code A His attitude gave me the impression that he thought I was emotional and he was clearly dismissive to my request. The officer did say that he would discuss the matter and he would ring me back.

Before the officer rang me back I rang him the following morning. I put it to him that I did not think he was not taking the matter seriously and I would be quite happy to write up the case myself and send it to Sir John HODDINOTT . His response was, you can do what you like and it was more or less said in those word_. I should clarify that I am not absolutely certa_ this was DC Code A but it is my belief it was. I told the officer that if that was his attitude that is exactly what I would do.

The next contact I had was from my sister w_ told me that DC Code A had been in contac_ with her and said he would like to statement from her. He mentioned it was his inten_ to have the interview filmed, as a film crew were in the process of following officers at wo_, she had apparently agreed, though she thought it rather strange. She did explain there was more to it than just a fall, which was what the officer seemed to be believing my complaint was all about. Again this was an indication he had not taken the matter seriously. I advis_ my sister to cancel the interview which was ???. DC Code A seemed put out according to my sister, because he had already made the arrangements for the film crew. It is my bel_ that he told them what the interview was to be about as he had discussed it with them.

I wish to complain that firstly if I have identified the correct officer then he is responsible for

breaching a confidence as he had no authority to discuss the details of my complaint to him wit_ a film crew.

Following this business with the film crew later that same day I telephoned Gosport Police Station and asked to speak to a senior officer. Not long after Inspector PEARSON telephoned me.

Inspector PEARSON dealt with the matter quite properly and advised me that he would arrange for an officer who could deal with the matter to contact. The following day I was contacted by DC MADDISON who made an appointment for my sister and I to see him on the 2nd October at Gosport Police station.

The interview took place and we gave DC MADISON only an outline of the case before he responded by saying he did not think the case was a matter for the Police. He qualified that by saying we should contact the General Medical Council .

I then gave him more specific detail to show my belief was this was indeed a police case and his views were not pertinent. I supplied him with all the relevant papers we had at that time and he photocopied them. This included copies of legislation, case law and extracts from Archbolds.

My sister also repeated her fears regarding the inaccuracy of the death certificate and the earlier comments of the registrar. She also expressed her concern that she was in jeopardy by agreeing to what the registrar had said because she had seen a sign there about making false statements. She told DC MADDISON however that she wanted to now give that evidence about what the registrar had said. She had been concerned that she could be fined £2000 as the sign warned. The meeting with DC MADDISON ended with him telling us he would further interview my sister when he would take a full statement from her regarding the death certificate and her reaction to the report from the health authorities, with particular reference to the statements made by Dr BARTON which were untrue. These are the two items already referred to in this statement.

DC MADDISON also told me I too would be interviewed to make a statement. To date these interviews have not taken place and neither of us has made a statement. This means that our evidence has never been submitted to the CPS within the file sent to them for advice.

DC MADDISON's comments were that he would approach his supervisors with a view to obtaining permission to see the medical papers and he hoped that the Doctor had not written up notes since our complaint was made to the Portsmouth Health Authority.

On 30th October I received a telephone call from MADDISON which has been recorded on my ansap_, I still have that tape. He told me that he had completed his investigation and submitted the pap_ to the CPS. He told me his opinion was still this was not a police matter and we should ??? it to the GMC. I later asked him if he had interview anybody prior to the submission of the papers. He told me he could not do that but had a conversation with the managing nurse wh_ he said was called Philip. By managing nurse he is referring to the person who had been prese_ during a lot of the time when my mother was being treated. DC MADDISON said Philip had made reference to whether the subject of medical intervention had been discussed as an option to my sister and I and he said it had. He said it had been said to us that medical intervention a_ per paragraph 8E of the report had been explain_ to us and we had agreed. I again emphatically denied ???

My first complaint against DC MADDISON is tha_ he ignored the fact that my sister and I have evide_ that the version given by Dr BARTON as per paragraph 8E was untrue. He failed to take that evidence from us and quite simply seems to have taken the word of Philip who was not ever there during the one and only conversation with Dr BARTON.

On 30th October 1998 (30/10/1998) DC MADDISON advised me he had submitted an advice file to the CPS. I asked him what his file comprised of and who he ??? interviewed. He said he had not interviewed anybody but he had had a conversation with the nurse Philip. I again emphatically denied the conversation referred to had taken place.

The above matter was the basis of my original complaint in a letter to the Hampshire Chief Constable on 20th November 1998 (20/11/1998). I wrote amongst other things that 'The case should be dealt with b_ officers with a degree of professionalism exceeding that of DI MORGAN and DC MADDISON'.

It is also my understanding that DC MADDISON did not obtain the medical notes as promised and they too did not form part of the file sent to CP_.

At the same time these things were happening on the first submission I also gathered papers concerning [redacted]

I knew DI MORGAN had my case papers so I telephoned Gosport Police Station to speak to her. She was on leave at that time so I spoke to her later upon her return from leave. I told her that I was [redacted]. She also told me she already sent the file to the CPS and I am clear about this. I asked her why it had been sent as she surely could not have even read it as it was her first morning back. She told me she had joined it with the other case of unlawful killing as it was "part and parcel of the same case".

I made it very clear to her that this was not the case. The two matters were entirely separate and I questioned her as to how she could have even read it. [redacted]

She further accused me of delaying things in so far as my mothers death was concerned. I think she said something like I had not been "very diligent". I pointed out to her that she was quite wrong and we had in fact started proceedings by complaining to the Portsmouth Health Authority before my mother had in fact even died and upon receipt of their report I immediately informed the police.

DI MORGAN also accused me of not being interested about what happened to my mother at the nursing home, which was quite improper of her because she knew nothing of the background to justify that comment.

RESTRICTED

Statement number: S4A

DOCUMENT RECORD PRINT

I have to admit that I was annoyed with Code A s attitude and I recall pointing out to her that h_ duty was to uphold the law and my right as a citizen to go the police and be dealt with properly.

In the case of Code A I should like to formally complain about the way she spoke and dealt with me during this telephone call. I make this complaint in particular because I now know she is the head of CID at Gosport.

In conclusion I should like to clarify my complaints. For the reasons I had outlined in this statement together with the written evidence I have already submitted, I believe the law has been broken by the hospital staff. I reported this to the Police and it is my view that the investigation has been flawed. DC MADDISON has not been thorough and has not taken the trouble to obtain all of the available evidence before submitting the case papers. Within this I include DI MORGAN, in addition to the earlier matter against her. It is my view she has failed to supervise this investigation in a manner which ensured it was dealt with thoroughly.

I should also like to make reference to the separate issue [redacted] I should like to be assured that all of the evidence I supplied Gosport Police was submitted to the lawyer to enable a decision. If that is the case then I realise I can take it no further, however I wish to give notice that it will form part of an overall report I intend to pursue with the Home Secretary.

Signed: Gillian M MacKENZIE

Signature witnessed by: Code A

RESTRICTED

Statement number: S2

DOCUMENT RECORD PRINT

STATEMENT PRINT

Surname: Code A

Forenames: Code A

Age: 49 Date of Birth: Code A

Address: PORTSMOUTH HEALTHCARE NHS TRUST CENTRAL OFFICE, ST JAMES HOSPITAL, LOCKSWAY ROAD, PORTSMOUTH, HAMPSHIRE

Postcode: PO48LD

Occupation: Code A

Telephone No.: Code A

Statement Date: 27/01/2000

Appearance Code: 1 Height: 1.56 Build:

Hair Details: Position Style Colour

Eyes: / Complexion: /

Glasses: Use:

Accent Details: General Specific Qualifier

Number of Pages: 8

I am employed by the Portsmouth Health Care NHS Trust and my role is that of Code A I have a professional nursing background.

I have been requested, by Detective Chief Inspector BURT of the Hampshire Constabulary, to make available a particular Portsmouth Health Care NHS Trust Health Record which relates to a former patient named Gladys RICHARDS who died on the Code A at the Gosport War Memorial Hospital.

Gosport War Memorial Hospital is a Community Hospital where the day to day care is provided by a team of nurses, therapists and managers. Clinical Assistants, who are usually local general practitioners, provide the routine medical cover by making daily visits to the wards and can be asked

to make additional visits as necessary. Each Code A visits weekly to conduct a ward round. There is no residential medical cover.

The nursing care is provided is non acute, for instance intravenous fluids would rarely be given. Subcutaneous fluids can be given, as can fluids and liquid feeds via a naso-gastric tube.

Daedalus Ward has twenty four beds; eight are for people needing slow stream stroke rehabilitation and sixteen are for people who meet the criteria for NHS continuing care. Mrs RICHARDS was a continuing care patient.

I have traced the Health Record which relates to Gladys RICHARDS and I will retain it, in my possession, in its original state.

I will produce the original Health Record for inspection or such other purpose as may be required in connection with the police investigation.

The original Health Record now has attached to it a Hampshire Constabulary exhibit label, which I have signed, marked LH/1 .

I have produced a complete, photocopied, facsimile of this health record and I have handed it to Detective Chief Inspector BURT. Attached to this copy Health Record is a Hampshire Constabulary exhibit label, which I have signed, marked LH/1/C .

In order to assist with the police investigation process I will introduce and comment upon where it might be helpful to do so, each page of the copy Health Record (LH/1/C). In order to achieve clarification each page of the copy Health Record (LH/1/C) has been marked with an individual pencilled reference eg, File Cover Sheet (LH/1/C/1).

In an attempt to further assist I will, where it is possible to do so, given an indication of who the author of certain entries, among the file notes, may have been. However, whilst I may so comment in good faith, I cannot guarantee the accuracy of these particular observations on my part.

File Cover Sheet - Front (LH/1/C/1)

This is the File Cover Sheet and it has, recorded upon it, information relating to the patient and subject of the Health Record namely Gladys RICHARDS. This Health Record bears the reference number G099198. The information includes the subject's name and date of birth - Code A Code A The subject's address is recorded as being 'Glen Heathers' Nursing Home, Code A Code A The subject's doctor (GP) is recorded as being Code A .

The File Cover Sheet has been stamped with an endorsement indicating that the subject, Gladys RICHARDS, died on the 21st August 1998 (21/08/1998).

Supply of Address Labels (LH/1/C/2)

This is a page with a number of adhesive pre-prepared address labels relating to the patient and designed to facilitate efficient administration.

File Divider - Correspondence (LH/1/C/3).

This represents an aid to efficient filing.

Provider Spell Summaries (LH/1/C/4 and 5)

A Provider Spell Summary is a computer generated form which is completed when a patient is either discharged from a hospital or dies. The form is completed by staff who add appropriate handwritten notes. There are two Provider Spell Summaries on the Health Record in question. Both forms, which are self carbonating, appear to have been inadvertently overwritten in places - more so in the case of LH/1/C/5.

The first form (LH/1/C/4) is hand dated the Code A It was completed on the occasion of the death of Gladys RICHARDS. I believe that the handwritten entries were made by Doctor J BARTON who is a visiting GP and Clinical Assistant at the Gosport War Memorial Hospital. I believe that the dates Code A and signature, lower down, were written by Staff Nurse GIFFIN.

The second (LH/1/C/5) is hand dated the 14th August 1998 (14/08/1998). It was completed on the occasion of the discharge and transfer of Gladys RICHARDS to the Royal Hospital Haslar. I believe that the date (14.8.98) (14/08/1998) and signature were written by Philip BEED who is a Clinical Manager. It is possible that the other handwritten entries were made by Philip BEED but I cannot be certain.

Letter from Royal Hospital Haslar (LH/1/C/6)

This letter, dated the 17th August 1998 (17/08/1998) is a discharge letter addressed to the Code A Code A Daedalus Ward, Gosport War Memorial Hospital. It provides information as regards the condition of Gladys RICHARDS on the occasion of her being discharged and transferred from the Royal Hospital Haslar back to the Gosport War Memorial Hospital. I am unable to comment on the authorship of this letter.

Letter from Royal Hospital Haslar (LH/1/C/7)

This letter, dated the 10th August 1998 (10/08/1998) is a discharge letter which was prepared on the occasion of the discharge and transfer of Gladys RICHARDS from the Royal Hospital Haslar to the Gosport War Memorial Hospital. It purports to have been signed by Code A a Staff Nurse.

Letter from Gosport War Memorial Hospital (LH/1/C/8)

This letter, dated the 14th August 1998 (14/08/1998) is a discharge letter which was written by Code A Code A on the occasion of the discharge and transfer of Code A from the Gosport War Memorial Hospital to the Royal Hospital Haslar. This letter was written on the back of LH/1/C/7.

Letter from the Portsmouth Health Care NHS Trust (LH/1/C/9)

This letter, dated the 5th August 1998 (05/08/1998) was written by Code A, a Code A Physician in Geriatrics, to Code A of the Royal Hospital Haslar. In this letter Code A ID refers to the fact that he has seen Code A, on Ward E6 at the Royal Hospital Haslar and undertakes to arrange for her transfer to the Gosport War Memorial Hospital.

File Divider - Clinical Record (LH/1/C/10)

This represents an aid to efficient filing.

(Medical) History Sheet (LH/1/C/11)

This form facilitates the recording of the subject's medical history. In the case of LH/1/C/11 both sides of a single page have been completed. There are seven, dated, entries covering the period of the 11th - 21st August 1998 (21/08/1998) inclusive. The first six entries appear to have been written by Code A while the seventh appears to have been written by Staff Nurse GIFFIN.

File Divider - Therapy and Nursing Notes (LH/1/C/12)

This represents an aid to efficient filing. All pages in this section (LH/1/C/13-22) make up the nursing records.

General Information Form (LH/1/C/13)

This form caters for the recording of various categories of general information. On the back of LH/1/C/13 there are some handwritten notes relating to the past medical history of, presumably, Gladys RICHARDS. I am unable to comment on the authorship of this form.

Summary Form (LH/1/C/14)

This form is designed for the recording of significant events. It has one entry written upon it. It is dated the 11th August 1998 (11/08/1998). I am unable to comment on the authorship.

Assessment Sheet (LH/1/C/15)

This form is designed to enable a comprehensive nursing assessment to be carried out in respect of a patient. I am unable to comment on the authorship of the entries which have been made upon it.

Abbreviated Mental Study (LH/1/C/16)

This form is designed to enable a basic assessment to be carried out of a patient's mental capabilities. It was not completed in this case.

The Barthel ADL Index (LH/1/C/17)

This form is designed to enable an assessment to be carried out of a patient's ability to undertake the activities of daily living (ADL). In the case of Gladys RICHARDS an assessment was made on the 11th August 1998 (11/08/1998). I am unable to comment on the authorship of this form.

Waterlow Pressure Sore Prevention/Treatment Policy (LH/1/C/18)

This form is designed to enable an assessment to be carried out of the degree of risk that a patient will develop pressure sores. In the case of Gladys RICHARDS an assessment was carried out on the 11th August 1998 (11/08/1998). I am unable to comment on the authorship of this form.

Lifting/Handling Risk Calculator (LH/1/C/19).

This form is designed to enable an assessment to be carried out of the degree of risk associated with lifting/handling a patient. It was not completed in this case.

Patient Medication Information (LH/1/C/20)

This form is used to record details of patient's medication. In this case there are two entries both dated the 11th August 1998 (11/08/1998). I am unable to comment on the authorship on these entries. This form is only a nursing record and in no way replaces the prescription sheet.

Contact Record (LH/1/C/21)

This form is used to record significant events in terms of patient/relative/doctor contact. In this case there are two sheets (four sides). There are seventeen entries and I am able to suggest that they may have been written by the following members of staff:

13/08/1998 Staff Nurse BREWER
14/08/1998 Clinical Manager Philip BEED
14/08/1998 CM Philip BEED
17/08/1998 Staff Nurse JOICE
17/08/1998 Staff Nurse COUCHMAN
17/08/1998 Staff Nurse JOICE
17/08/1998 Staff nurse COUCHMAN
17/08/1998 CM Philip BEED
18/08/1998 CM Philip BEED
18/08/1998 CM Philip BEED
18/08/1998 CM Philip BEED
18/08/1998 Staff Nurse JOICE
18/08/1998 **Code A**
19/08/1998

19/08/1998 CM Philip BEED

21/08/1998 Staff Nurse JOICE

21/08/1998 Staff Nurse GIFFIN

Nursing Care Plan (LH/1/C/22/1-4)

A Nursing Care Plan form (LH/1/C/22) was, in this case, commenced on the 12th August 1998 (12/08/1998). There are six, subsequent, dated entries covering the period of the 12th August 1998 (12/08/1998) until the 19th August 1998 (19/08/1998) inclusive. The majority of these entries may have been made by Code A I am unable to comment on the authorship of the entry dated the 17th August 1998 (17/08/1998).

The Nursing Care Plan document embraces four other pages which are designed to enable various aspects of nursing care to be monitored. The pages are headed - Nutrition (LH/1/C/22/1). Constipation (LH/1/C/22/2). Bowel Movement Calendar (LH/1/C/22/3 and Personal Hygiene (LH/1/C/22/4). Various entries have been made on these forms. I am unable to comment on authorship other than where the signature is legible.

File Divider - Prescription Sheets & Observation Charts (LH/1/C/23)

This represents an aid to efficient filing.

Prescription Sheet (LH/1/C/24)

This is a six sided, folding, form upon which details of drugs, prescribed and given to a patient, are recorded. Exceptions to prescribed orders are also given.

File Divider - Investigations (LH/1/C/25)

This represents an aid to efficient filing.

Biochemistry (LH/1/C/26)

No entries recorded.

Haematology, Blood Transfusions and Immunology Reports (LH/1/C/27)

No entries recorded.

Portsmouth Pathology Service Microbiology Report (LH/1/C/28)

This form indicates the results of microbiological tests conducted in respect of various MRSA screening swabs taken from Mrs Gladys RICHARDS on the 11th August 1998 (11/08/1998) and reported on, on the 14th August 1998 (14/08/1998).

Radiology Report (LH/1/C/29)

This form indicates the result of an 'x' ray examination of Gladys RICHARDS right hip conducted on the 17th August 1998 (17/08/1998).

Radiology Report (LH/1/C/30)

This form indicates the result of an 'x' ray examination of Gladys RICHARDS hips conducted on the 14th August 1998 (14/08/1998).

File Cover Sheet (Back) (LH/1/C/31)

This form has, printed upon it, an administrative index.

Moving on from the Health Record I am able to produce a photocopy of a Portsmouth Health Care NHS Trust 'Risk Event Record' form which has, attached to it, a Hampshire Constabulary exhibit label, which I have signed, marked LH/2.

This form, comprising of three sides, was commenced by Staff Nurse BREWER on the 13th August 1998 (13/08/1998) after Gladys RICHARDS suffered a fall at the Gosport War Memorial Hospital. Further entries on this form have been made by Philip BEED and Code A S who is the Senior Nurse Co-ordinator.

On the 20th August 1998 (20/08/1998) I received a handwritten communication from Mrs LACK, the daughter of Mrs Gladys RICHARDS, in which she posed a series of questions concerning the care which had been provided for her mother. I am able to produce a photocopy of this document which has, attached to it, a Hampshire Constabulary exhibit label, which I have signed, marked LH/3 .

As a result I initiated an internal enquiry which was carried out by the then Acting Service Manager Code A Code A completed her enquiry on the 11th September 1998 (11/09/1998). I am able to produce a photocopy of the Enquiry Report which has, attached to it, a Hampshire Constabulary exhibit label, which I have signed, marked LH/4 .

Subsequently on the 22nd September 1998 (22/09/1998) a letter was sent, by the Trust, to Mrs LACK, in reply to her communication (LH/3). It was signed by Mr MILLETT , the Chief Executive and drew on the findings of Mrs HUTCHINS enquiry. I am able to produce a copy of this letter which has, attached to it, a Hampshire Constabulary exhibit label, which I have signed, marked LH/5 .

On the 11th December 1998 (11/12/1998) I received a telephone call from Detective Constable whose name, I believed was MADESON . As a result of the call I arranged for a report to be prepared by Doctor A LORD , a Consultant Geriatrician, employed by the Trust.

Dr LORD was the Consultant to Daedalus Ward to which Mrs RICHARDS was admitted. The report set out to explain the care provided to Mrs RICHARDS prior to her death. A copy of the report, signed by Dr LORD and dated the 22nd December 1998 (22/12/1998), was forwarded to the Police on the 19th January 1999 (19/01/1999). I am able to produce a photocopy of Dr LORD's Report which has, attached to it, a Hampshire Constabulary exhibit label, signed by me, marked LH/6 .

RESTRICTED

Statement number: S2

DOCUMENT RECORD PRINT

Whilst Mrs RICHARDS was admitted to the Gosport War Memorial Hospital she was x-rayed on two occasions. The dates on which the diagnostic imaging took place were 17th August 1998 (17/08/1998) and 14th August 1998 (14/08/1998) (see LH/1/C/29-30 respectively). The x-rays are currently in my possession and I will retain them. I will make the x-rays available for examination, as required, for the purposes of the police investigation. The x-rays have attached to them Hampshire Constabulary exhibit labels, signed by me, marked LH/7 and LH8 respectively.

Signed: Code A

Signature witnessed by: R J BURT DCI7410

RESTRICTED

Statement number: S3

DOCUMENT RECORD PRINT

STATEMENT PRINT

Surname: LACK

Forenames: LESLEY FRANCES

Age: 64 Date of Birth: Code A

Address: Code A

Occupation: RETIRED

Telephone No.: Code A

Statement Date: 31/01/2000

Appearance Code: 1 Height: 1.58 Build:

Hair Details: Position Style Colour

Eyes: / Complexion: /

Glasses: Use:

Accent Details: General Specific Qualifier

Number of Pages: 20

I am the natural daughter of Gladys Mable RICHARDS (Nee BEECH) who was born on the Code A Code A.

My mother died on the 21st August 1998 (21/08/1998) whilst she was an admitted patient at the Gosport War Memorial Hospital.

I am a retired Registered General Nurse (RGN). I retired during 1996 after 41 years, continuously, in the nursing profession. For 25 years, prior to my retirement, I was involved in the care of elderly people. For 20 years, prior to my retirement, I held supervisory and managerial positions in this particular field of nursing.

My mother was a resident in two nursing homes from 1991 or thereabouts. The first was located in the Basingstoke area and the most recent was the 'Glen Heathers' Nursing and Residential Home,

Milvil Road, Lee on Solent, Hampshire . My mother spent approximately four years at the 'Glen Heathers' Home. On admission to Glen Heathers my mother was ambulant - able to go up and down stairs and walk well.

She was generally well, physically, but had the onset of dementia and became increasingly forgetful. At the beginning of 1998 my mother's dementia was becoming more marked and she had become less able physically. She was inclined to wander and following a change in her medication began to have falls.

However, despite this my mother was able to stand, walk and attend the toilet. I used to take her out for trips in my car. Her last visit to my home occurred during Christmas 1997.

My mother left the 'Glen Heathers' Home on the 29th July 1998 (29/07/1998) and was admitted to the Haslar Hospital, Gosport .

My mother had suffered a fall, at the Home, at approximately 1450 hours during the afternoon of that day. She was eventually taken to Haslar Hospital, by ambulance, at approximately 2100 hours that evening where she was diagnosed as having broken a neck of femur on her right side.

Whilst it may not have a direct bearing on my main concerns surrounding my mother's death, which I will describe later in this statement, I would like to point out that I did have serious reservations as regards the standard of care which my mother was receiving whilst residing at the 'Glen Heathers' Home.

In fact, following my mother's admission to the Haslar Hospital on the 29th July 1998 (29/07/1998), I had decided that, if and when my mother recovered, she would not be returning to 'Glen Heathers' Home.

I was asked by the Social Services Department why I had made this decision and, in response, I prepared and provided a handwritten account describing what I considered to be a catalogue of unacceptable events which had led me to conclude that the level of care which my mother was receiving at 'Glen Heathers' Home was no longer acceptable to me.

The handwritten account was prepared, by me, during August 1998 and I consider that it represented a truthful statement which dealt with various events and circumstances which I had observed or had become aware of during the months which preceded my mother's admission to the Haslar Hospital.

I will not, for the purposes of this statement, refer in detail to the matters described in that account but I will, by way of introducing the events which followed, make some brief references, drawing on my personal recollections and my notes, to my involvement in the events leading to my mother's admission to the Haslar Hospital on Wednesday the 29th July 1998 (29/07/1998).

I was a frequent and regular visitor to the 'Glen Heathers' Home whilst my mother was residing there and I played an active role in helping her in her daily routines. My visits were generally daily in the last 8 months of her life.

I recall that I was unable to get to the 'Glen Heathers' Home at lunchtime on Wednesday the 29th July 1998 (29/07/1998). I telephoned the home to inform them that I would be going there later in the afternoon.

When I arrived, at approximately 1550 hours, I saw that my mother was lying in an armchair. She appeared to have an anxious expression on her face. I asked a care assistant to help me to move my mother into a more comfortable sitting position which, together, we tried to do but, as a result, my mother screamed out in pain.

I saw John PERKINS , an RGN and the Home's Matron/Manager and I asked him if there was anything wrong with my mother which might account for her pain. He told me that she was fine.

I clearly knew that this could not be the case but I was not in a position to do anything more at that time. I had to leave the home at 1615 hours in order to meet a flight at Southampton Airport. I said that I would return later.

I arrived home, from the Airport, at approximately 1810 hours. I found a message on my telephone answer machine, timed at 1528 hours, from a woman I knew as Margaret who was an RGN who worked at the home. Margaret stated that my mother had experienced a fall earlier and, whilst she was alright, she was a bit noisy and upset. Margaret asked if I could attend the home, before teatime, and sit with her, to calm her down.

I immediately telephoned the home, at approximately 1815 hours and spoke to John PERKINS. I told him about the message from Margaret and pointed out that I had seen him, at the home, after the message had been left on my answer machine.

John PERKINS agreed that this was the case but stated that when he had spoken to me he was not aware of my mother's fall. He stated that he had learned about it during the 1800 hours 'hand over' process when Margaret had gone off duty.

I asked John about my mother's current condition and he said that she was OK. I told John that I would call again later. I had to go out in the meantime.

I returned home at approximately 2030 hours. I found three messages from the home on my telephone answer machine:

1. 2008 hours - from Code A - stating that my mother was quite agitated and noisy and inviting me to attend and sit with her.

2. 2029 hours - stating that my mother was calling as if she may be in pain. She had been put to bed and consideration was being given to calling a doctor.

3. 2030 hours (approximately) - from a woman named Sue, a member of the night staff - stating that she was sorry but she was sure that my mother had a fractured femur. She went on to state that when she had started work she had been told, by John, to see my mother who had been shouting for ages. Sue stated that when she did so the injury appeared obvious and, as a result, she had called an ambulance.

I telephoned the home and advised the staff that I would meet the ambulance at the Haslar Hospital.

On admission to the Haslar Hospital my mother was 'x' rayed and the diagnosis was confirmed. Furthermore, it was observed that the injury was consistent with my mother having been 'walked' after the fall had occurred. There was a shortening of the limb and an external rotation of the right foot. My mother was extremely upset and was crying and wailing in fear.

I subsequently sought a full explanation from the 'Glen Heathers' Home about the events which occurred on the 29th July 1998 (29/07/1998). As a result I saw a woman named Pauline , an RGN and consultant/advisor to the home.

Pauline read to me from several statements which had been obtained from members of staff at the home. I was not given copies.

During this process I was advised that my mother had fallen at 1450 hours in the dining room.

The statements read to me, by Pauline, indicated that my mother had been walked to the lounge, at some time after the fall had occurred, and, at some time thereafter, walked to the bedroom from the lounge.

The statements confirmed the following key points.

1. The fall had occurred at 1450 hours.

2. The serious injury which had apparently been sustained during this fall was not identified or even suspected by the staff despite my mother clearly showing signs of being in considerable and sustained pain.

3. My mother was walked on two occasions after apparently sustaining the injury which appears to have seriously aggravated her condition.

4. A doctor was not called to the home.

5. My mother's condition was not effectively identified until a member of the night staff correctly diagnosed the likely cause of her severe discomfort and pain at or about 2030 hours when an ambulance was called to the home and she was taken to the Haslar Hospital.

I can produce a copy of the handwritten notes which I prepared. These notes have attached to them a Hampshire Constabulary exhibit label which I have signed and which bears the reference LFL/1 .

Following her admission to the Haslar Hospital, at approximately 2100 hours on Wednesday the 29th July 1998 (29/07/1998), my mother underwent a surgical operation. This was carried out during the following day, Thursday the 30th July 1998 (30/07/1998), following a discussion with the consultant who thought my mother should be given the chance to remain ambulant.

My mother received a replacement hip, on her right side and remained in the Haslar Hospital for a further eleven days until Tuesday the 11th August 1998 (11/08/1998).

I visited my mother every day during this period and, I my view, when taking into account the serious injury which she had sustained and the trauma she had suffered, my mother appeared to make a good recovery during this period.

Prior to her discharge and transfer to the Gosport War Memorial Hospital, my mother was responding to physiotherapy, able to walk a short distance with the aid of a zimmer frame and no longer required a catheter. Her medication had been reduced and she was able to recognise family members and make comments to us which made sense.

She was, with encouragement, eating and drinking naturally and as a result the drips, which had facilitated the provision of nourishment after the operation, had been removed.

Significantly, my mother was no longer in need of pain relief. It was quite apparent, to me, that she was free of pain.

Such was the extent of my mother's recovery that it was considered appropriate to discharge her and transfer her to the Gosport War Memorial Hospital where she was admitted to Daedalus Ward on Tuesday the 11th August 1998 (11/08/1998). This was the first occasion that my mother had been admitted to this particular hospital.

I will now deal with the matters which arose during the following ten days culminating in my mother's death on Friday the 21st August 1998 (21/08/1998).

In doing so I will draw upon my personal recollections and also refer to a further set of handwritten notes which I prepared, whilst sitting at my mothers bedside, while she was still alive with my sister Gillian MACKENZIE , as I was unhappy with the events that had befallen my mother.

I telephoned the Complaints Department at Portsmouth Health Care Trust on Wednesday 19th August from Daedalus Ward and spoke to Code A in depth. Having listened, she advised me that everything must be in writing. I continued adding to my notes - hence the use of different pens. I prepared these notes on the advice of Code A , the Quality Manager for the Portsmouth

Health Care Trust, to whom I expressed my serious concerns about the care and treatment given to my mother by staff at the Gosport War Memorial Hospital.

The handwritten notes, a copy of which I passed to Code A, are in the form of a basic chronology and I incorporated within them a series of questions which focused on particular areas of concern in respect of which I sought an explanation or clarification from the hospital authorities. Following presentation of my notes we were visited on the ward by Code A on 20.8.98 (20/08/1998).

I produce the original handwritten notes which I prepared comprising of 5 numbered pages. These notes have attached to them a Hampshire Constabulary exhibit label which I have signed and which bears the reference LFL/2.

I am in possession of a further page of notes, in my handwriting, which I prepared at the time. I cannot now recall whether this additional page was copied to Code A with the other pages. This single page has attached to it a Hampshire Constabulary exhibit label bearing the reference LFL/2A which I have signed.

Many of the events and occasions I refer to in this statement took place in the presence of my sister Gillian MACKENZIE. The addition to the notes were made when my sister and I read them prior to passing them to Code A as requested. Gillian remained at the hospital with me from 18th to 21st August 1998 (21/08/1998) inclusive, either of us leaving for very short periods only.

I visited my mother the day of her admission and discussed her present condition with the staff and on the following day after her admission to the Gosport War Memorial Hospital, namely Wednesday the 12th August 1998 (12/08/1998), I was rather surprised to discover that I could not rouse her. As she was unrousable she could not take nourishment or be kept hydrated.

I enquired among the staff and I was told that my mother had been given the morphine based drug 'Oramorph' for pain. This also surprised me. When my mother had been discharged from the Haslar Hospital, the day before, she had not required pain relief for several days.

I was distressed to observe my mother's deteriorated condition which significantly contrasted with the level of recovery which had been achieved following treatment at the Haslar Hospital during the period after the surgical operation to replace her hip.

I was told that my mother had been calling out, showing signs of being anxious, and it was believed that she was suffering pain. They did not investigate a possible cause. I consider it likely that she was in need of the toilet.

I became concerned that perhaps the staff at the Gosport War Memorial Hospital may have

misinterpreted my mother's anxious and occasionally noisy behaviour. She had been showing signs of dementia for some time, prior to her admission to the Haslar Hospital and she was prone to becoming very anxious at times particularly when she wanted to use the toilet.

One of the consequences of being rendered unrousable, by the effects of 'Oramorph' was that no fluids could be given to my mother and this, together with the abandonment of other forms of rehabilitation, would have served to inhibit or prevent the recovery process which had begun prior to her admission to the Gosport War Memorial Hospital.

I would like to clarify an important concern I felt at this stage.

I believed that it was possible, having regard to the level of recovery which my mother had achieved upon being discharged from Haslar Hospital the day before, that her reported behaviour could have been wrongly attributed to the presence of pain as opposed to other possible causes, such as anxiety, which could have been addressed naturally or by the use of alternative and milder forms of medication. I believe that the possible misinterpretation of my mother's behaviour is a particularly significant factor in this case.

In the circumstances which I have just described I consider that it is possible that my mother's signs of anxiety could have been misinterpreted for pain whereas, subsequently, it appears likely that the fact that my mother, after having fallen, and was clearly showing signs of being in pain, these signs were either ignored or dismissed as being the result of her dementia.

During the following day, Thursday the 13th August 1998 (13/08/1998), I received a telephone call, at approximately 1400 hours, from my daughter, Karen READ , who is a qualified nurse. As a result I went to the Gosport War Memorial Hospital to see my mother.

I arrived at the Gosport War Memorial Hospital at approximately 1545 - 1600 hours. I immediately saw that my mother appeared to be uncomfortable and in pain. She had an anxious expression, was weeping and was calling out. She was sitting in a chair and appeared grossly uncomfortable.

I spoke to several trained and untrained members of staff expressing my concern over my mother's condition. I was told that there was nothing wrong and that her behaviour was the result of her dementia. I was not satisfied with this explanation and I was convinced that my mother was in pain.

Later, at approximately 1630 - 1700 hours, a care assistant came into my mother's room. She told me that my mother had fallen from a chair earlier that day.

I immediately enquired if my mother had been examined by a doctor but the care assistant did not know. I also asked if my mother could be x-rayed but I do not recall receiving a response to this request. I was able to give my mother a fruit drink which I had brought with me and she drank it

readily. The whole glass.

A little later I saw an RGN who was doing the medicine round at approximately 1730 - 1800 hours. I was, at this time, feeding my mother by tea spooning her with some soup. My mother was quiet then. The RGN asked me 'Do you think your mother is in pain?' In reply I expressed the view, 'Not at the moment while I'm feeding her'. I was rather taken aback by the RGN's rather curt reply, 'Well you said she was in pain'. I replied 'Yes, she has been very uncomfortable since I got here. Do you think she has done some damage?' The RGN replied 'No, she only fell on her bottom from her chair'. I was shocked by this seemingly casual and insensitive remark - when this accident could very easily have caused damage and had not been checked.

I remained with my mother until approximately 1945 hours that evening (Thursday the 13th August 1998 (13/08/1998)). After I had fed her she once again became distressed and showed signs of being in considerable pain. She remained in this condition, throughout, until my departure. I left very distressed as my mother was crying out and I could do nothing for her.

After I arrived home I received a telephone call from Daedalus Ward at the Gosport War Memorial Hospital. The caller stated that, 'When we put your mother to bed she was in great pain and she may have 'done something'. The doctor feels it's too late to send her to Haslar and our x-ray unit is closed. We will give her 'Oramorph' for the night to keep her pain free and x-ray her in the morning'.

I was becoming extremely concerned about what was happening to my mother.

It appeared, to me, at that time, that my mother had suffered a potentially serious fall at some time prior to my daughter's telephone call, to me, at approximately 1400 hours. I have, earlier in this account, referred to conversations which I had, during the afternoon and early evening, with two members of staff who both knew about, and referred to, the fall.

Despite the fact that my elderly mother was known to have suffered a fall, so soon after a hip operation, and she so clearly showed signs of anxiety, discomfort and pain, the reason was not properly explored and diagnosed.

This, in fact, resulted in what I believe was an avoidable delay of eight hours, in the first instance, before it was acknowledged, at approximately 2130 hours, that my mother, 'may have done something'.

I reiterate that I was, at that time, advised that the proper facilities (x-ray unit) for diagnosing my mother's condition, at the Gosport War Memorial Hospital, 'were closed and that the doctor, 'feels it is too late to send her to Haslar'.

Instead my mother was given 'Oramorph' for pain relief and remained, effectively untreated, at the

Gosport War Memorial Hospital overnight.

I strongly believe that the failure, on the part of the staff at the Gosport War Memorial Hospital, to properly and promptly take steps to accurately diagnose my mother's condition, on Thursday the 13th August 1998 (13/08/1998) and immediately initiate action to effectively deal with the cause by seeking a transfer to the Haslar Hospital where treatment was available, represented an example of a pattern of omission and failure which, ultimately, contributed in her death.

The following morning, Friday the 14th August 1998 (14/08/1998) I went to the Gosport War Memorial Hospital. I arrived as my mother was being taken, on a trolley, to the x-ray department. She was still deeply under the effects of the 'Oramorph' drug. I accompanied my mother whilst she underwent the x-ray process the associated movements of which caused her great pain.

When the x-ray process was completed we returned to my mother's ward and I was called into an office by Philip, the Ward Manager, where I also saw Dr BARTON . I was told 'Your worst fears of last night appear to be true, we have rung Haslar and they have accepted her back'.

My mother was admitted to the Haslar Hospital, for the second time, during the late morning of Friday the 14th August 1998 (14/08/1998). I accompanied my mother and she was expected. The Consultant was called and he saw my mother in the Casualty Department immediately.

The Consultant showed me the x-rays and the position of my mother's limb, something else which I had observed, the day before, at the Gosport War Memorial Hospital.

My mother's right hip, which had been the subject of a surgical 'replacement' operation 14 days previously, had become dislocated from its socket. Within one hour of being admitted my mother underwent a successful surgical operation to manipulate the hip back into the socket.

This did, indeed, confirm my fears about the care my mother had received. She had fallen, whilst at the Gosport War Memorial Hospital, and it had taken almost 24 hours to secure effective treatment.

I remained at the hospital until approximately 10pm (2200).

My mother did not regain consciousness until approximately 0100 hours on Saturday the 15th August 1998 (15/08/1998) due to the amount of analgesia required for the procedure. I telephoned the ward at this time as I was anxious. The night staff told me she had just regained consciousness.

She was the catheterised so that there was no need to use a slipper pan. She had a drip as she had been given nil by mouth since before the x-ray procedure carried out on Friday the 14th August 1998 (14/08/1998).

She remained pain free, in a full length leg splint. The Consultant showed me that both legs were level and straight. No analgesia was required and she was able to use a commode for the toilet with

weight bare for transfer. My mother began to eat and drink and the drop was removed. Her fluid balance was acceptable. I visited daily.

Such was my mother's progress that during the following day, Sunday the 16th August 1998 (16/08/1998), she became easily manageable.

The issue I wish to highlight, at this point, is that when my mother's condition was correctly diagnosed and treated her pain and discomfort were removed and she recovered well.

My mother was examined early on Monday the 17th August 1998 (17/08/1998) when a transfer back to the Gosport War Memorial Hospital was recommended. I contacted the Haslar Hospital by telephone at approximately 0830 hours as requested and was told that my mother would be transferred that morning.

I offered to attend the Haslar Hospital so that I could pack my mother's things and accompany her but I was told that there was 'No need, she is fine'.

I arrived at the Gosport War Memorial Hospital at approximately 1045 hours with Gillian MACKENZIE and we were told that the ambulance, carrying my mother, was due at midday or thereabouts.

We returned to the Gosport War Memorial Hospital at approximately 1215 hours.

On entering through the swing doors to the ward I heard my mother screaming. When I arrived at my mother's room a care assistant said 'You try feeding her. I can't do it. She is screaming all the time'.

My mother had a staring anxious expression. She was griping her right thigh, at the sight of the surgical operation, tightly.

She uttered the words 'Do something, do something. The pain, the pain. Don't just stand there. I don't understand it. The pain, the pain, the pain. Sharp, sharp. This is some adventure'. Gillian MACKENZIE was present.

An SRN came into the room because of the noise my mother was making. I removed the sheet covering my mother as she lay no her bed and pointed out the awful position she was in. She was lying awkwardly towards the left side and the hips were uneven.

My mother was crying in pain and I said to the RGN, 'Can we please move her'. We move her together with our arms together under her lower back and out other arms under her thighs. We placed her squarely on her buttocks and within minutes she had stopped screaming.

I was concerned that my mother's position had not, apparently, been checked when she had been transferred from the ambulance. I was also concerned about the fact that, once again, the source of

the pain had not, immediately, been sought.

I left my sister, at the Gosport War Memorial Hospital, at around this time and I went to the Haslar Hospital. This would have been about lunchtime.

I was so appalled at my mother's condition, discomfort and severe pain that I went to the ward in which she had been treated, E3, and enquired about her condition upon discharge earlier that morning.

When I had, earlier that day, telephoned E3 ward and I had been further advised that my mother was eating, drinking, using a commode and able to stand if aided. The Consultant responsible for my mother was, I was told, happy that she could be sent back to the Gosport War Memorial Hospital.

It is, perhaps, worthwhile re-emphasising that this was the level of recovery my mother had achieved on the morning of Monday the 17th August 1998 (17/08/1998) prior to being discharged from the Haslar Hospital. Whilst she was an elderly and frail lady she was not suffering with a fatal illness. Her discharge notes from Haslar refer to her care for the next 4 weeks, to ensure her progress was maintained.

Upon leaving Haslar Hospital's E3 ward, after confirming the information I had earlier been given, I met the doctor who had been present in the Casualty Theatre at the time of my mothers' second operation which took place on Friday the 14th August 1998 (14/08/1998). This doctor had been with the Consultant when al the procedures were explained to me, upon my mother's admission, that day. The doctor asked 'How's your mother?'.

I explained the current position to him in detail. I told him that she was in severe pain since the transfer which had been undertaken a short time earlier. He said 'We've had no referral. Get them to refer her back. 'We'll see her'.

I then returned to the Gosport War Memorial Hospital where I noted that the Charge Nurse Manager frequently checked my mother. He acknowledged my concern and the fact that my mother was obviously in pain.

I asked for my mother to be x-rayed and enquired what had happened between my mother having left the Haslar Hospital and her arrival at the Gosport War Memorial Hospital.

It was acknowledged that 'something' had happened. The Charge Nurse was concerned for my mother's pain and analgesia was given three times between her admission and 1800 hours.

Philip, the Ward Manager, agreed that my mother needed an x-ray to establish if further damage had been done to the hip.

The x-ray department refused to act upon forms of authority prepared and signed on behalf of the

doctor who was unavailable.

An appointment for x-ray was made for 1545 hours as the doctor who had been called was expected at approximately 1515 hours.

The Charge Nurse did all he could to expedite this, keeping me informed and constantly checking my mother's obvious severe pain. He administered pain relief in readiness for the x-ray procedure. He was courteous and attentive at all times.

Dr BARTON arrived and I left the room as requested whilst she examined my mother. She stated that whilst she did not think that there was further dislocation the x-ray could go ahead. A review would be conducted later when the result of the x-ray was known.

I accompanied my mother to the x-ray department. My mother remained in pain despite the pain relief which had been administered to her. I as not allowed to accompany her as I had been the previous week. Whilst I waited outside I could hear my mother wailing, while the x-ray was taken.

In due course I returned to the ward and I was told that there was no dislocation but obviously 'something' had happened. I was not given sight of the x-ray.

I was told, by either the Ward Manager or Doctor BARTON, that my mother would be given 'Oramorph' for the pain, four hourly, through the night and she would be reviewed in the morning. I told them that Haslar would accept her back but Dr BARTON felt that was inappropriate.

I told Dr BARTON and the Ward Manager that I had been to the Haslar Hospital that morning, explained what was happening and told them that Haslar would be prepared to re-admit my mother. I considered this was essential so that the 'cause' of my mother's pain could be treated and not simply the pain itself.

Dr BARTON said that, 'It was not appropriate for a 91 year old, who had been through two operations, to go back to Haslar Hospital where she would not survive further surgery'.

The following day, Tuesday the 18th August 1998 (18/08/1998) I returned to the Gosport War Memorial Hospital with my sister in the morning. Upon arrival we were told by, the Ward Manager Mr Philip BEED , that whilst my mother had undergone a peaceful night she had, however, developed a massive haematoma in the vicinity of the operation site which was causing her severe pain.

The plan of management, as explained to us by the Ward Manager, was to use a syringe driver to ensure my mother was pain free at all times so that she would not suffer when washed, moved or changed in the event she should she become incontinent.

The outcome of the use of the syringe driver was explained to my sister and I fully. Drawing on my

experience as a nurse I knew that the continuous use of morphine, as a means of relieving her pain, could result in her death. She was, at that time, unconscious from the effects of previous doses of 'Oramorph' and therefore unable to take nourishment by mouth. It was my understanding that it would not have been possible for nourishment to have been given to my mother, by way of a drip, whilst she remained at the Gosport War Memorial Hospital.

As a result of seeing my mother in such great pain I was becoming quite distressed at this stage. My sister asked the Ward Manager, 'Are we talking about euthanasia? It's illegal in this country you know'. The Ward Manager replied 'Goodness, no, of course not'. I was upset and said, 'Just let her be pain free'.

The syringe driver was applied and my mother was catheterised to ease the nursing of her. She had not had anything by mouth since midday Monday 17th August 1998 (17/08/1998).

A little later Dr BARTON appeared and confirmed that a haematoma was present and that this was the kindest way to treat my mother. She also stated, 'And the next thing will be a chest infection'.

I considered that this was a totally insensitive remark to make to someone, such as myself, who was experiencing some of the feelings associated with the first stages of bereavement.

I would like to clarify the issue of my 'agreement' to the syringe driver process. It was not a question, in my mind, of 'agreement'.

I wanted my mother's pain to be relieved. I did not 'agree' to my mother being simply subjected to a course of pain relief treatment, at the Gosport War Memorial Hospital, which I knew would effectively prevent steps being taken to facilitate her recovery and would result in her death.

I also wanted my mother to be transferred back to the Haslar Hospital where she had, on two occasions, undergone operations and recovered well. My mother was not, I knew, terminally ill and, with hindsight, perhaps I should have challenged Dr BARTON more strongly on this issue.

In my severe distress I did not but I do believe that my failure to pursue the point more vigorously should not have prevented Dr BARTON from initiating an alternative course of action to that which was taken, namely a referral back to the Haslar Hospital where my mother's condition could have been treated and from where an offer had already been made to do so.

I accept that my mother was unwell and that her physical reserves had been depleted. However she had, during the preceding days and weeks, demonstrated great courage and strength. I believe that she should have been given a further chance of recovery especially in the light of the fact that her condition had, it would seem likely, been aggravated by poor quality service and avoidable delay experienced whilst in the hands of those whose responsibly it was to care for her.

My mother's bodily strength allowed her to survive a further 4 days using her reserves. She suffered kidney failure o the 19th August and no further urine was passed. The same catheter bag remained in place until her death.

Because the syringe driver was deemed to be essential following the night of several doses of pain relief my mother's condition gradually deteriorated during the next few days, as I knew it inevitably would and she died on Friday the 21st August 1998 (21/08/1998).

I passed, as I have previously mentioned, a copy of the notes I had prepared (LFL/2) to Mrs HUMPHREY.

In reply I received a letter from Max MILLETT , the Chief Executive of the Portsmouth Health Care NHS Trust, dated the 22nd September 1998 (22/09/1998).

I can produce a copy of this letter which has, attached to it, a Hampshire Constabulary exhibit label which I have signed and which bears the reference LFL/3.

Whilst there are a number issues which cause me concern I would like to make some particular comments on the contents of this letter.

In order to do this I have been provided, by DCI BURT, with a typed copy of the letter (LFL/3). This copy, to which is now attached a Hampshire Constabulary exhibit label bearing the reference LFL/3A and signed by me, was constructed to enable me to add handwritten comments which I have done. I feel, however, that I should point out that where I have chosen not to record such a comment this does not imply that I necessary agree with, or accept, what has been stated.

I have been shown, by DCI BURT, a copy of an Enquiry Report which has attached to it 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 this Enquiry Report (LH/4). The copy, to which is now attached a Hampshire Constabulary exhibit label bearing the reference LFL/4 and signed by me, was constructed to enable me to add handwritten comments which I have done. I, once again, 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 have had sight of a report, prepared by Dr LORD and dated the 22nd December 1998 (22/12/1998), which has attached to it a Hampshire Constabulary exhibit label bearing the reference LH/6 and signed by me.

If this report is supposed to represent an independent assessment of the treatment which my mother received at the Gosport War Memorial Hospital then I find this difficult to accept.

Dr LORD was the consultant for Daedalus Ward at the Gosport War Memorial Hospital but, in her

own words '... did not attend to Mrs RICHARDS at all ...'.

Dr LORD's report appears to have been prepared by reference, some time after the event, to information, notes and documents supplied by colleagues with whom she worked on a regular basis.

I have been shown, by DCI BURT, a Portsmouth Health Care NHS Trust Risk Event Record. Attached to this document is a Hampshire Constabulary exhibit label bearing the reference LH/2 which I have signed.

I have examined this document, which comprises of 3 sides of paper and I would like to make the following observations.

On page 1, at 12(a) after the words 'seen by?' there is a handwritten entry, 'Dr BRIGG'.

I believe that this contradicts information contained in the letter from the Portsmouth Health Care Trust (LFL/3) dated 22nd September 1998 (22/09/1998) where, at point (4), it states that Dr BARTON was present on the ward just after my mother's fall.

Furthermore, at 12 (a), there is a further handwritten entry which states 'Advised by telephone - analgesia & RV mane'. This may be cross referred to an entry in my mother's Health Care Record (LH/1/C/21) which is dated 13.8.98 (13/08/1998) and timed at 1300.

At 12(b) it states, in reply to the question, 'Has next of kin been informed? The corresponding 'Yes' has been positively ticked and dated 13/8/98 (13/08/1998). Furthermore it states that I had been informed by telephoned.

I was not informed and I was not telephoned. My statement shows I was on the ward and had great difficulty in finding anyone to confirm my mother was injured.

It is my opinion that the Risk Event Record is incorrect. My mother was not seen by Dr BRIGG.

Part 'E' of the Risk Event Record shows that a particular question, which appears among a series of 'tick box' questions and states, 'Slipped, tripped or fell on the same level', has been positively answered. In my view this is incorrect. The normal height of the seat would be between 17 and 25 inches so my mother's fall to the ground would have involved a considerable drop.

I have been shown, by DCI BURT, a copy of the Portsmouth Health Care Trust Health Record. Attached to this Health Record is a Hampshire Constabulary exhibit label bearing the reference LH/1/C.

This health Record relates to my mother and I would like to make the following comments in respect of this document.

On the page marked LH/1/C/6, which is a copy of a Discharge Letter from the Royal Hospital Haslar , I note the comment, 'She can, however, mobilise fully weight bearing'. I wish to highlight the fact

that this relates to my mother's condition on the 17th August 1998 (17/08/1998).

On the page marked LH/1/C/8 there is a copy of a handwritten note, apparently signed by Philip BEED, which is addressed to Haslar A&E and is dated 14th August 1998 (14/08/1998). In these notes it states, 'No change in treatment since transfer to us 11/8/98 (11/08/1998), except addition of Oramorph etc.

I would comment that no analgesia was required until the staff at the Gosport War Memorial Hospital first used Oramorph when my mother was agitated and probably in need of the toilet on the 11th August 1998 (11/08/1998) which was the day of her admission from the Royal Hospital Haslar.

I saw the my mother was deeply unconscious when I visited her on the 12th August 1998 (12/08/1998). In my view this medication probably affected the opportunity to offer nourishment as early as the 11th August 1998 (11/08/1998).

On page LH/1/C11 I note, with some concern, an entry under the date of the 11th August 1998 (11/08/1998) in what I believe is Dr BARTON's handwriting, the comment, 'I am happy for nursing staff to confirm death'.

My mother was well and enjoying a good convalescence following a major operation. She was able to eat and drink. She was able to stand whilst requiring help with all daily living events.

Perhaps this comment may be considered, by some, as being 'normal' procedure for aged admissions but not in my experience. Such a question may, perhaps, be considered if the patient was suffering from a terminal illness and death is likely or imminent. The evidence does not suggest that my mother was in this condition.

On the same page (LH/1/C/11) there is an entry under the date of the 14th August 1998 (14/08/1998) which is once again, I believe, in Dr BARTON's handwriting. It states 'Fell out of chair last night'.

Further reference to the Risk Event Record (LH/2) shows, at point (9), that the accident occurred on the 13th August 1998 (13/08/1998) at 1330 hours and it will be recalled that the Portsmouth Health Care Trust letter (LFL/3) states that Dr BARTON was on the ward following accident.

I query whether, in fact my mother was seen at all.

A further comment, in the same entry, states, 'Daughter aware and not happy'. I reiterate that I was 'not happy' because I could get nothing done for my mother who was simply given pain relief without any apparent attempt to discover the cause of her discomfort.

Finally, in the same entry, the question is raised by, I believe Dr BARTON, 'Is this lady well enough for another surgical procedure?' This question was not, however, raised with me.

On the reverse side of page LH/1/C/11, under an entry dated the 17th August 1998 (17/08/1998),

there are references to my mother's condition following the operation on 14.8.98 (14/80/1998) as per the nurse's notes of Haslar, not to her condition on 17.8.98 (17/08/1998).

There is a comment, I believe in Dr BARTON's handwriting, '... now appears peaceful'. I know that my mother screamed and cried in the period following her re-admission.

My mother was only 'peaceful' being given Oramorph on 3 occasions which rendered her quiet and unconscious. In fact this treatment had rendered my mother incapable of taking any nourishment from this point and she did not regain consciousness again.

I would like to draw attention to the fact that there are no Doctor's notes from the 18th - 21st August 1998 (18/08/1998), (21/08/1998).

On the same page, under the date of the 21st August 1998 (21/08/1998) there is an entry which, I believe, is also in Dr BARTON's handwriting which I feel I must challenge. Contrary to what Dr BARTON has written I strongly believe that my mother did not have a rattly chest nor any other symptoms of Brocho-pnuemonia.

On page LH/1/C/21 and on the following 3 pages, also so marked and headed 'Contact Record', I note that no entries appear to have been made over the period of the 11th/12th August 1998 (11/08/1998) (12/08/1998).

On page LH/1/C/21, under an entry dated the 13th August 1998 (13/08/1998) there are comments which clearly indicate that my mother was not seen by a doctor or examined by way of x-ray following her fall at 1.30pm (1330) that day.

It was not until 7.30pm (1930) or 8.30pm (2030) that it was appreciated that my mother's hip was the cause of my mother's pain. Telephone contact, only, was made and advice sought and given by a doctor who did not know my mother.

I was present on the ward and repeatedly sought help for my mother. I was casually informed by a Health Care Assistant, that my mother had indeed had a fall.

In my opinion there was a serious lack of action for a post operative patient in view of her obvious gross 'discomfort' which was brought to the attention of all grades of staff by myself. The comment included in the entry, 'daughter informed' may refer to the phone call received after I returned home at approximately about 9pm (2100) - 10pm (2200) that evening.

On the same page, under an entry dated the 17th August 1998 (17/08/1998) there appears to be a reference to my mother being in pain and distress but no action was taken.

There is an 'added' comment which refers to the fact that when my mother was transferred there was, 'no canvas under patient ...' In my view this represented a serious breach of work procedures and

should be questioned.

I consider that the circumstances of my mother's transfer from the Royal Hospital Haslar, to the Gosport War Memorial Hospital, should be the subject of investigation. How was she brought from Haslar? How was she lifted? How was she transferred to her bed? Was the bed moved from the wall? How was she deposited in her bed? And by whom? Who was present?

This was a woman, 2 days post operative, who was transferred on a sheet. How could this have happened? And why?

Who was informed, and when, as regards her degree of pain which was very obvious when I arrived 30 minutes after this entry was apparently made.

On the following page there is a further entry which is also dated the 17th August 1998 (17/08/1998) and time at 1305 hours. This entry does not refer to my mother's awful position, which I observed upon my arrival, or the fact that I asked the RGN to look at the way in which she was lying and to adjust her to be equally on both hips.

It was at this point that I told the staff that the Royal Hospital Haslar would be prepared to re-admit my mother. The surgeon had said that she should not be in pain.

I once again point to the fact that my mother was pain free and mobilising prior to her transfer.

It should be noted there is no entry, on the 17th or 18th August 1998 (17/08/1998) (18/08/1998), regarding the fact that my sister and I were told that our mother had a massive haematoma. I can find no written evidence of this fact.

I see that no contact notes were made on the 20th August 1998 (20/08/1998).

In an entry dated the 21st August 1998 (21/08/1998) there is a reference to the fact that, 'daughters visited during morning'. I would state that, in fact, we were constantly at the Gosport War Memorial Hospital, day and night, from the 17th August 1998 (17/08/1998) until the time when my mother died.

I would like to comment, in respect of the Nursing Care Plan on the 2 pages marked LH/1/C/22, lacks information regarding the events that occurred.

With reference to the pages marked LH/1/C/22/4, headed 'Personal Hygiene' and 'Care Plan', there is, in my opinion, a gross lack of attention to the needs of daily living. Not even face and hands were washed and there are no entries at all on the 17th, 19th, or 20th August 1998 (20/08/1998).

Finally, by reference to the page marked LH/1/C/22/1 and headed 'Nutrition' I comment that, in my opinion, this form is sadly lacking in information.

There are only 3 entries in total and no entries at all in respect of the 12th, 17th, 18th, 19th or 20th August 1998 (20/08/1998).

Furthermore there is no acknowledgement of the fact that my mother was having NIL BY MOUTH due to her induced unconscious state by the giving of pain relief only for 5 days prior to her death and during previous days of the 11th, 12th and 13th August 1998 (13/08/1998).

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 comment that in my opinion, when comparing it as a residual account of events with the Portsmouth Health Care Trust's Health Record (LH/1/C), it supersedes the latter in terms of quality and content.

Having examined the Medical Record (AF/1/C) I consider it to be totally accurate as regards the condition and treatment/care afforded to my mother Mrs Gladys RICHARDS. There is attention to detail and all information contained therein is as I remember.

I would particularly like to highlight a particular issue and refer to a page in the Medical record marked (AF/1/C/11).

It should be noted that after my mother's initial admission to the Royal Hospital Haslar, when it was uncertain if she would survive, the doctor, to his credit, has written, 'she is to be kept pain free, hydrated and nourished'.

To me this indicated that there was a will, and an intention, to afford to my mother total care whilst she was alive.

I wish to draw attention to the excellent standard of treatment which my mother received while at the Royal Hospital Haslar. She was nursed with care and consideration with, significantly, attention being paid to hydration and nourishment. There was an expectation, for the immediate future, on her transfer to the Gosport War Memorial Hospital.

In my view this is in direct contrast, in all aspects, to the standard of care and attention which my mother received at the Gosport War Memorial Hospital during the last 6 days of her life the most notable feature being the refusal to refer her back, once again, to the Royal Hospital Haslar when an offer had been received to accept her.

Signed: Lesley Lack

Signature witnessed by: R J BURT

RESTRICTED

Statement number: S1

DOCUMENT RECORD PRINT

STATEMENT PRINT

Surname: Code A

Forenames:

Age: 59 Date of Birth: Code A

Address: MEDICAL RECORDS OFFICE ROYAL HOSPITAL HASLAR, HASLAR ROAD, GOSPORT, HAMPSHIRE
Postcode: PO122AA

Occupation: MEDICAL RECORDS Code A

Telephone No.: Code A

Statement Date: 25/02/2000

Appearance Code: 1 Height: 1.71 Build:

Hair Details: Position Style Colour

Eyes: / Complexion: /

Glasses: Use:

Accent Details: General Specific Qualifier

Number of Pages: 1

I am the Code A for the Commanding Officer and I work at the Royal Hospital Haslar.

I have been asked, by Detective Chief Inspector BURT , to provide a copy of a medical record relating to a former patient named Gladys Mabel RICHARDS who received treatment at this hospital during July and August 1998.

I produce a true copy of the medical record in question and it has, attached to it, a Hampshire Constabulary exhibit label marked AF/1/C which is signed by me.

Each of the 99 page sides, forming part of the copy file and containing information, is marked with an individual reference which is derived from the master reference AF/1/C/1-99.

I have retained the original copy of the medical records and attached to it is a Hampshire

RESTRICTED

Statement number: S1

DOCUMENT RECORD PRINT

Constabulary exhibit label marked AF/1 which is signed by me.

I will make the original file available for inspection in connection with the police investigation process.

I also produce a 2 page schedule which details the 11 x-ray images which were taken of Mrs RICHARDS whilst she was admitted to the Royal Hospital Haslar. The schedule has attached to it a Hampshire Constabulary exhibit label marked AF/2 which is signed by me. The x-ray images, retained by me, are similarly labelled and marked AF/2/1-11 .

Signed: Code A

Signature witnessed by: R J BURT

RESTRICTED

Statement number: S4

DOCUMENT RECORD PRINT

STATEMENT PRINT

Surname: MACKENZIE

Forenames: GILLIAN

Age: 68 Date of Birth: Code A

Address: 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 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 Code A 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 '.

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.

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 Code A 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 Code A 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 Code A

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 Code A 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, Code A office. I told her or Barbara ROBINSON , who was possibly dealing with the matter in Code A 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 Code A she said that would have been explained at the time. I told Code A 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 Jenny BREWER and a health support worker COOK '. 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 Jean , I think and one is named Linda . Linda 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 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, Linda, 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?

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?'

RESTRICTED

DOCUMENT RECORD PRINT

Statement number: S4

Signed: Code A

Signature witnessed by:

GLADYS RICHARDS

COMMENTS ON REVERSE OF HASLAR FILE PAGES:

HASLAR FILE

AF/1/C/10 - Comments on reverse
Why should there be a problem with a haematoma at Gosport with a platelet count of 260. My husband with [redacted]. Note the clotting APTT. Death was caused cerebral vascular accident due to leukaemia.
G M MacKENZIE

There was no write up or evidence of a haematoma on the Gosport file.

We were fully aware and in the picture and agreed no life support machine in the event of cardiac arrest etc. In fact we brought up the subject. DNR but in the event of terminal complications my mother should be kept pain free, hydrated and nourished.

(Practical ??? ??? time).

Whilst I was in agreement with proposed procedures in the event of cardiac arrest etc that does not mean that I accept dehydration and morphine overdose for a non existent haematoma or to 'finish off' a 91 year old at the whim of a nurse/doctor or the policy of the hospital (BEED/BARTON/LORD) at Gosport.

AF/1/C/21 - Comments on reverse
This was confirmed with nursing staff by my sister and I when we visited Gosport prior to transfer. I made the point that my mother would attempt to get out of chair by herself if she could not summon nurses help. I made the point I was relieved she was going into a single room with a large glass window opposite the nursing desk so that a constant eye was kept on her. How is it that nursing staff did not know how long she had been on the floor after the fall if she was in her room. I suspect no heed had been taken to our warnings and concern and she was in the day room unsupervised, where my niece saw her shortly after her fall on the 13.08.98 (13/08/1998).
(Karen REED).

AF/1/C/28 - Comments on reverse
Isn't a haematoma a complication?

Why were there no procedures at Gosport. Why we we told by P BEAD that mother was dying when there was no evidence of a haematoma except in BEED's mind?

AF/1/C/34 - Comments on reverse
Drugs PRN following manipulation dislocated hip after fall at Gosport 13/8.

Compare with Gosport.

AF/1/C/43 - Comments on reverse
Haloperidol 1mg with fractured hip.

Compare with Gosport.

AF/1/C/46 - Comments on reverse
2.5mg Morphine following surgery at Haslar but 40-200mg at Gosport for a non existent haematoma!

Morphine

Operation day 2.5 30/7
2.5 0150 31/7
2.5 1908
2.5 1920 1/8
2.5 0720 2/8

Co-codamol 2 tablets 1/8 - 7/8 see chart.

Haloperidol following op for fractured hip.

2 mg.

Compare with Gosport.

AF/1/C/48 - Comments on reverse
There was no ??? or morphine prescribed as per Gosport and the treatment was ok - no haematoma at Gosport reported 11-14 or 14-17 at Haslar. No evidence of Haematoma at Gosport.

AF/1/C/63 - Comments on reverse
My mother was not refusing food.

AF/1/C/64 - Comments on reverse
This is not the appetite of a dying woman.

AF/1/C/65 - Comments on reverse
My mother's appetite may not have been up to steak and chips but she was eating.

AF/1/C/66 - Comments on reverse
Before transfer to Gosport, 11.8.98 (11/08/1998) my mother was eating but no food or fluid given unless my sister was there to give it. Reference on Gosport file to food being refused was because my mother was too sedated with Oramorph soon after arrival - administered by BEED etc. See Gosport files.

AF/1/C/84 - Comments on reverse
This backs my statement, after 3 days at Gosport 11-14/8/98 (11/08/1998), (14/08/1998) my mother was dehydrated.

AF/?? - Comments on reverse
Haematomas are not uncommon but you do not 'finish off' the patient because of them. What was the procedure at Haslar/Gosport, following a serious fall down stone steps my heel of the shoe went into the ankle, the ankle bone of the other foot - massive haematoma followed on ankle and sole of foot. Treatment bandage, feet up (raised) bed rest for five days, with co-codomol and a packet of frozen peas. I was not sedated!

AF/1/C/88 - Comments on reverse
Why didn't BARTON at Gosport diagnose on 13.8.98 (13/08/1998) and why delay and further stress in carrying out x-ray at Gosport before transfer 24 hrs after fall to Haslar.

Fully alert when not sedated as per Gosport Oramorph for non existent pain by BEED.

AF/1/C/89 - Comments on reverse
Diet and fluids were day before discharge to Gosport after surgery hip replacement.

Code A

Gosport.

Why should there be a problem with a haematoma at

[redacted]

Note the clothing APPT. Death was caused

[redacted] external vascular accident due to ventricular.

Code A

There was no write-up or evidence of a haematoma.

on the Gosport ward.

We were fully aware of the process and

agreed no life support machine in the event of

cardiac arrest etc. In fact we brought up the

subject. DNR. but in the event of terminal

complications Code A should be kept pain free

hydrated & nourished.

(Code A Code A phone time.)

Whilst I was in agreement with proposed

procedures in the event of cardiac arrest etc

that does not mean that I accept dehydration

& morphine overdose for a non-existent haematoma

& to 'turn off' a 91 year old at the whim

of a Nurse / Doctor in the policy of the hospitals.

(Code A Code A) re Gosport.

Code A

Code A

This was confirmed with Nursing Staff by Code A and I when we visited Gosport prior to transfer. I made the point that Code A would attempt to get out of chair by herself if she could not summon Nurses help. I made the point I was informed she was going into a Single room with a large glass window opposite the Nursing desk so that a constant eye was kept on her. However that Nursing Staff did not know how long she had been on the floor after the fact if she was in her room. I suspect no heed has been taken to our warnings and concern and she was in the Day room unsupervised, where Code A found her shortly after the fall on the 13.08.98 Code A.

Code A

Is it a haematoma a complication?
Why were there no procedures on Gospel.
Why was we told by Code A that there
was signs was have was no evidence of
a haematoma except. as Code A said?

Code A

Drugs PRN following manipulation dislocated hip not taken at Hospital 13/8.
compare with Hospital

Code A

Hasopenmost. buy wire fastened up.

compare with Gosport.

Code A

Code A

Code A

Code A

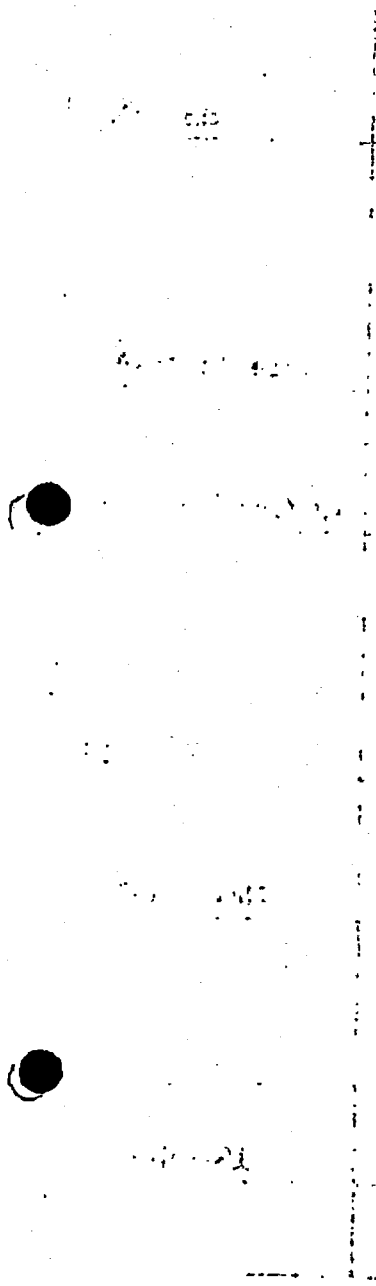
There was no pain on discipline practiced as per Gospels.
& No training was of — no examination as Gospels reported
12 - 14 or 14 - 17 as Hadas. No evidence of Examination as
Gospels.

Code A

Code A was not requiring food.

Code A

This is not the appropriate dump
location.



Code A

Code A's appetite may not have been up to snuff — but she was eating

Code A

Before transfer to Gosport 11. 8. 98.

Code A was eating, but no food in

his glass. Code A was keen to

give it. Reference on Gosport file to food being

refused was because Code A was too

sedated with oramorph, soon after admission

administered by Code A etc. See Gosport files

Code A

Code A

Code A

Code A

Code A

Code A

Code A

Why did it Code A at Gosport diagnose on 13.8.98 & why delay & further steps in carrying out X-ray at Gosport. before transfer 24 hrs after face to Haslar.

Fully alert when not sedated as per Gosport. Example to not steroid pain by Code A

Code A

Haemarrhoids are not uncommon but I do not think of the patient because I have. What was the procedure at Hôtel Dieu? Following a serious fall down stone steps my heel of the shoe went into the ankle bone of the other foot. — massive haemarrhoid followed in ankle and sore foot Treatment: bandage, feet up (raised) bed rest — two to three days with co-codamol and a packet of frozen peas. I was not sedated.

RESTRICTED

Statement number: S3A

DOCUMENT RECORD PRINT

STATEMENT PRINT

Surname: RICHARDS

Forenames: LESLEY FRANCES

Age: O.18 Date of Birth:

Address: Code A

Occupation: RETIRED REGISTERED GENERAL NURSE

Telephone No.: Code A

Statement Date: 11/08/2004

Appearance Code: 1 Height: 1.58 Build:

Hair Details: Position Style Colour

Eyes: / Complexion: /

Glasses: Use:

Accent Details: General Specific Qualifier

Number of Pages: 4

I originally made a statement to the police dated 31st January 2000 (31/01/2000). I made this statement in my previous married name of LACK. I have been known by my maiden name of RICHARDS since 1/4/2000 (01/04/2000). I have been asked about my mother, Gladys RICHARDS , operation site.

I inspected my mother's wound where she had her replacement hip on a number of occasions at the Gosport War Memorial Hospital . I remember distinctly that the scar had healed perfectly.

In my original statement I refer to Phillip BEED telling me that my mother had developed a massive haematoma and that this was the cause of her pain and the reason for the use of Diamorphine . This

conversation took place on Tuesday 18th August 1998 (18/08/1998).

On Code A died. I was present at her death and shortly afterwards I and my daughter Karen READ laid my mother out.

We washed her face and hands and brushed her hair. We then changed her into a clean nightie. In order to change the nightie we had to turn her on to both sides so I had a clear view of her body. There was no sign of a haematoma nor did she have any pressure sores.

If my mother had a haematoma I would have expected to see a raised bruised area of some magnitude with discolouration of the skin.

I have been asked if my mother showed any symptoms of suffering from Bronchopneumonia.

The symptoms for bronchopneumonia are a raised temperature, increased secretions from the nose, mouth and chest, sterterous breathing (difficulty in breathing) and laboured respirations.

My mother's breathing was soft and gentle and quiet throughout the last days of her life.

I am now aware that my mother was given Hyocine which suppresses secretions but this would not prevent symptoms of bronchopneumonia from being present. In my opinion my mother had no signs and symptoms of suffering from bronchopneumonia.

I have been asked about the events relating to the registering of my mothers death.

On 24th August 1998 (24/08/1998) I collected a sealed envelope from the administration office at the Gosport War Memorial Hospital, this contained my mothers death certificate.

I took this envelope to the Registrars Office at the Civic Offices in Gosport.

I handed the envelope to the registrar, a lady I now know as Helen PASSMORE .

She opened it and asked me what was my relationship to the deceased.

I told her that I was Code A and she began to fill out the relevant documentation.

I have registered the deaths of a number of relatives as well as a number of elderly people who had no next of kin when I was director of nursing in a nursing home, so I am conversant with the procedure.

Helen PASSMORE handed the certificate supplied by the hospital and said something to the effect of "Can you read through this and confirm that it is correct".

I looked at the certificate and the first thing that I noticed was that the entry was 1a which normally means that there would be a b or a 2 indicating more than one contributing factor to the cause of death.

There was only one entry and the cause of death was given as 1(a) Bronchopneumonia.

I knew that my mother didn't have Bronchopneumonia at the time of her death so I said to the Registrar "This is not correct". She replied "What do you mean?" I said "My mother didn't have bronchopneumonia. She was in hospital following surgery and a fall. She definitely didn't have bronchopneumonia".

Helen PASSMORE said "Don't say another word, if you say another word I will have to stop this interview and call the Coroners Officer and there will be a post mortem". I was by this time extremely distressed and in tears. I didn't want my poor mother to be cut up. I wanted her to be left in peace. I didn't argue any further and so I said "Ok, just give me the certificate so that I can get mother cremated".

I accepted the certificate with my mother's cause of death given as Bronchopneumonia (LR/DC/1).

I went home and told my daughters Peta and Karen what had happened shortly afterwards.

On the first occasion of my speaking to the police at Gosport Police Station I raised the matter of Code A mother's death certificate with DC MADDISON . I told him that I was concerned that I had accepted

an incorrect death certificate and that I might be guilty of an offence. He assured me that I wouldn't be prosecuted over the matter.

I also raised the matter of Code A 's death certificate with Code A when I made my original statement.

Taken by: Code A

Signed: Lesley RICHARDS

Signature witnessed by:

RESTRICTED

Statement number: S204E

DOCUMENT RECORD PRINT

STATEMENT PRINT

Surname: Code A

Forenames

Age: 43 Date of Birth: Code A

Address: Code A

Occupation: CIVIL SERVANT

Telephone No.: Code A

Statement Date: 11/08/2004

Appearance Code: 1 Height: Build:

Hair Details: Position Style Colour

Eyes: / Complexion: /

Glasses: Use:

Accent Details: General Specific Qualifier

Number of Pages: 1

Further to my statement dated 4th March 2004 (04/03/2004). At 1545 hrs on Wednesday 11th August 2004 (11/08/2004) I handed the original medical records belonging to Gladys Mabel RICHARDS , born Code A , died 21/8/1998 (21/08/1998) to DC424 ROBINSON (JR/10).

These records include the x-rays dated 5/7/96 (05/07/1996).

Taken by:DC424 ROBINSON

RESTRICTED

Statement number: S204E

DOCUMENT RECORD PRINT

Signed: Code A

Signature witnessed by:

LEONARD GRAHAM

Leonard Graham

Date of Birth: Code A Age: **75**
Date of admission to GWMH: **16th August 2000**
Date and time of Death: **13.40 hours on 14th September 2000**
Cause of Death: **Bronchopneumonia**
Lewy Body Dementia
Post Mortem: **Yes**
Length of Stay: Code A **days**

Mr Graham's past medical history:-

Lewy Body Dementia
Hallucinations
Prostatectomy
BOO
CA lung
Hernia
Bronchoscopy
UTI
Idiopathic Parkinson's disease

Mr Graham was born in Scotland. He joined the Navy and moved to the south coast in 1946 where he met and married his wife. They had 2 daughters and up until 1987 Mr Graham worked in a dockyard. Mr Graham lived with his wife in their own three bedroom house. Mr Graham' Code A was his main carer. Mr Graham was admitted to the Gosport War Memorial Hospital on 4th September 2000 after being admitted to the Queen Alexander Hospital on 16th August 2000 with chest infection, urinary tract infection, poor mobility and with swallowing difficulties. It was noted that Mr Graham was allergic to codeine and haloperidol.

On admission a handling profile was completed on 4th September 2000 noting that Mr Graham did not appear to be aware of his surrounding, he was not complaining of pain and was to be nursed on an air mattress.
A Barthel ADL index was completed on the 4th and 10th September 2000 both scoring 0.
Care plans commenced on 4th September 2000 for catheter care/hygiene/ constipation and night care.

4th September 2000

Admitted to Daedleus ward from John Pounds ward Queen Alexander Hospital for continuing care. The transfer form notes that Mr Graham incontinent of urine and faeces, requires hoist to transfer, needs a pureed diet and thickened fluids and requires feeding. It also noted that Mr Graham was being nursed on a Huntley bed.

Clinical notes state prognosis poor.

Contact record seen by Dr Lord – soft moist diet. [redacted]

[redacted]

5th September 2000

Remains the same. No reports of agitation.

6th September 2000

Brighter today. Engaging with other people. Less dehydrated.

9th September 2000

Catheterised.

11th September 2000

Barthel 2/20 – poor oral intake. Can be aggressive to nursing staff. Very confused. Overall prognosis poor.

Wife seen discussed Lewy Body Dementia appreciates that Mr Graham is quite unwell and too dependent now for Discharge planning.

In the event of chest infection need to discuss transfer back to acute with wife if antibiotics required.

Contact record seen by Dr Lord wife seen and is aware of poor outlook would like husband home if possible.

12th September 2000

Seen by SLT continue puree diet. Monitor chest status and review oral feeding if signs of chest infection.

14th September 2000

Unresponsive, nursing staff noted grey colour. Became agitated unable to obtain BP or oxygen sats. Given 2.5mg diamorphine S/C explained to wife that difficult to know exactly what was happening possible clot from legs going to lungs.

13.40 hours death confirmed by P ? C Nurse and S Webb.

15th September 2000

Cause of death: Lewy Body Dementia. Contacted by wife concerned re cause of death – surprised and asked if people could die of dementia – given details about post mortem.

Discuss with Dr Lord discussion with wife – best to refer to coroner for post mortem.

Discussion with coroner's office – for post mortem.

Discussion with wife – explained case referred to coroner for post mortem tomorrow.

BJC/20
LEONARD GRAHAM
75

Lewy Body Dementia with hallucinations and infection, probably chest. This was treated but he continued to deteriorate. He had a sudden terminal event and was given an appropriate small dose of diamorphine. He died rapidly.

PL grading A1

Code A

Code A

DOCUMENT RECORD PRINT

Officer's Report

Number: R11H

TO:
STN/DEPT:

REF:

FROM: Code A
STN/DEPT: MCIT W

REF:
TEL/EXT:

SUBJECT:

DATE: 04/02/2003

Sir

Re. Action 253.

I have visited Mrs Dorcas Elsie GRAHAM Code A Mrs Code A has concerns regarding the death of her husband Leonard GRAHAM Code A at the Gosport War Memorial Hospital on 14th September 2000 (14/09/2000).

His GP was Code A of the Portchester Health Centre .

The circumstances are as follows.

Mr GRAHAM had suffered with Parkinsons disease and Lewybody disease for some time. As a result of this he did suffer with hallucinations on occasions but other than this was very fit and active, so much so that on the 12th August 2000 (12/08/2000) he went ballroom dancing with Code A

On 16th August 2000 (16/08/2000) Mr GRAHAM suffered a urinary tract infection and was admitted to the QA Hospital at Cosham . He was taken off all medication in order to try and ascertain the cause of the infection. After a week in hospital he developed pneumonia and there were concerns that he would not recover. After two days though he started on his way to a complete recovery. His swallow reflex was affected by this bout of pneumonia so he was fed pureed food which his wife took the responsibility for feeding him.

On 4th September Mr GRAHAM was transferred to Daedelus Ward at the Gosport War Memorial Hospital. Dr LORD was the consultant and she told Mrs GRAHAM that it was too early to perform an assessment on her husband and this would be done the following week.

During the first week at the Gosport War Memorial Hospital Mr GRAHAM's health started to improve. Although he was not incontinent he had been catheterised as the staff said that it would mean less work. Although Mr GRAHAM felt well enough to try and stand the staff would not allow this, he was fully coherent and able to watch TV. Mrs GRAHAM continued to visit at least twice daily in order to feed her husband.

DOCUMENT RECORD PRINT

On 13th September 2002 (13/09/2002) Mr GRAHAM appeared to have a slight cold and was very tired, at dinner time members of the family asked him to be taken out of the chair and put back into bed as there was a danger of him falling asleep and sliding out of the chair. This was not done until Mrs GRAHAM arrived that evening and found him asleep but slumped in the chair.

Around mid-day on Thursday, 14th September 2002 (14/09/2002) Mrs GRAHAM received a telephone call from a female who stated that she was her husbands physiotherapist at the hospital and enquired as to how Mrs GRAHAM would feel about her husband coming home. Mrs GRAHAM stated that there would be nothing that she would like more but pointed out that the Ward Charge nurse, Phillip BEAD had stated that it would take weeks to organise the care. This female stated that Mr GRAHAM was ready to return home and that she could arrange the full care package within a couple of days.

Mrs GRAHAM went straight to the hospital and told her husband what was happening to which he replied, "that would be great."

Mrs GRAHAM then spoke to the Charge Nurse Phillip BEAD who queried this, stating that the physiotherapist had not been on duty that day. In any case Mr. GRAHAM had developed an infection where the catheter had been inserted, this was just about to be treated so she was asked to wait in another room.

After 10 - 15 minutes Phillip BEAD came to get Mr. GRAHAM and stated that her husband had taken a bit of 'a funny turn' during the procedure but was alright now. Dr ISON was present in the room and she stated that his chest was clear and that his heart rate was ok. Mrs GRAHAM stated that her husband was conscious, able to converse but did look unwell. Apparently his face kept twitching as though he was getting spasms of pain but did not cry out. Her husband indicated that he was feeling pain from the area where they had just performed the procedure on the catheter.
Phillip BEAD insisted on making Mrs. GRAHAM a cup of tea and told her that he was just going to give her husband an injection for the pain. He also stated that it might be a good idea for her to get her daughters to the hospital.

BEAD then asked Mr GRAHAM to turn over onto his left hand side which he did unaided. BEAD then gave him an injection into the top of his leg or buttock (recorded on records as 2.5 mg of diamorphine). Almost immediately Mr GRAHAM closed his eyes and within 10 minutes he was dead.

The staff on the ward stated that the death certificate would not be ready until the following Monday.

Mr. GRAHAM rang the hospital the next day and spoke to a registrar who stated that the certificate was ready. The cause of death was given as Dementia. Mrs GRAHAM queried this as death had been so sudden and unexpected so DR ISON and Dr LORD stated that a post mortem would be conducted. The primary cause of death given after the post mortem was bronchial pneumonia and secondary was Lewybody dementia.

Mrs GRAHAM stated that to the best of her knowledge her husband had not been prescribed any medication via a syringe driver, but believes he was sedated at night. She holds copies of all her husbands hospital medical records and the post mortem result.

I have informed her that Operation Rochester is an ongoing enquiry and she is aware and will be

DOCUMENT RECORD PRINT

attending the meeting at Whiteley on 5th February 2003 (05/02/2003).

Expert Review

Gladys Richards

No. BJC/41

Date of Birth: 13 April 1907

Date of Death: 22 August 1998

On 30 July 1998 Mrs Richards suffered a fall at the Glenheathers Nursing Home where she lived. She fractured her right neck and femur and was admitted to the Royal Haslar Hospital where she underwent a closed relocation of her right hip.

She was transferred to the Gosport War Memorial Hospital on 11 August 1998 for continuing care. She was readmitted to the Royal Haslar Hospital on 14 August 1998 for a reduction of her dislocated right hip and was readmitted to Gosport War Memorial Hospital on 17 August 1998. Plan on admission was to continue Haloperidol and only to give Oramorph in severe pain.

Mrs Richards, on the 18 August, was still noted to be in great pain at which point it was proposed that she was started on subcutaneous Diamorphine/Haloperidol/Midazolam.

Mrs Richards was noted to be much more peaceful on 21 August although her condition was noted to be very poor.

There is criticism made that the starting dose of 40mgs Diamorphine seemed excessive when starting the syringe driver but it was noted that Mrs Richards opiate requirement had increased considerably in the fifteen hours before the driver was started. Code A considered that the opiates were not considered to be implicated in her death. Code A felt the Diamorphine dose was too high and probably shortened her life but she seemed "unlikely to survive unless she had been left in severe pain (screaming)".[GR1]

GR1 I have not seen an officer's report from the family in this case.

GMC – v – Code A

CHRONOLOGY: PATIENT G – Code A

Date of Birth: Code A

Date:	Event:	Source:	Page(s):	Comments:
5/3/98	Reviewed by Code A at Dolphin Day Hospital. *Episodes of breathlessness are not too bad. Hasn't had any episodes for three weeks until the early hours of this morning. Feels that anxiety brings them on. Has found diazepam beneficial. Has not had oedema. Backache still a considerable problem. Able to get around on his scooter. Has whole body dystonia with very little stiffness, mild tremor affecting left upper limb. Able to transfer off scooter and walked about 25 paces with a stick and a little assistance of one person. Pulse 72 and regular. Heart sounds normal, chest clear. Wonder if he could have had problems with intermittent left ventricular failure, but overall symptoms not too bad at present. Taking Leva-dopa for Parkinsons. Medication: Sinemet, amlodipine, ranitidine, diazepam, solpadol 5-8 a day.*	Correspondence	140	

Solicitors Code A

GMC – v – Code A

CHRONOLOGY: PATIENT G – Code A

Date of Birth: Code A

Date:	Event:	Source:	Page(s):	Comments:
5/3/98	Reviewed by Dr Lord at Dolphin Day Hospital. *Episodes of breathlessness are not too bad. Hasn't had any episodes for three weeks until the early hours of this morning. Feels that anxiety brings them on. Has found diazepam beneficial. Has not had oedema. Backache still a considerable problem. Able to get around on his scooter. Has whole body dystonia with very little stiffness, mild tremor affecting left upper limb. Able to transfer off scooter and walked about 25 paces with a stick and a little assistance of one person. Pulse 72 and regular. Heart sounds normal, chest clear. Wonder if he could have had problems with intermittent left ventricular failure, but overall symptoms not too bad at present. Taking Leva-dopa for Parkinsons. Medication: Sinemet, amlodipine, ranitidine, diazepam, solpadol 5-8 a day.*	Correspondence	140	

		Clinical notes	635	
19/6/98	Reviewed by Dr Lord at Dolphin Day Hospital. *Loss of weight since last seen. Low in spirits but settling in. Able to get out of bed with assistance of one person. On a soft diet. Bowels regular. Breathless occasionally, but denies angina. Oedema not a problem. Has had two falls since moving to Rest Home. Hallucinations not a problem in last few days. Seen after Levodopa and was extremely dystonic, affecting body, right upper and lower limbs. Transfers extremely hazardous, had to be steadied by two people. Levodopa to be reduced. Need to ascertain whether he will remain at Rest Home over next few months.*	Correspondence	134-138	
	Referral to Dr Lord: Has moved to Merlin Rest Home. Has developed dystonic movements involving face, trunk and arms. Loss of independence and mobility. Possible visual hallucinations due to medication.	Correspondence	515	

	Cunningham suffers from Parkinson's and hallucinations. Rest home say he is a difficult man to manage. They find his mobility is either excellent or non-existent.	Correspondence	52	
22/6/98	Reviewed by Code A (psychiatrist) at GWMH. *Reviewed on behalf of Dr Banks. Has Parkinson's. Has experienced some visual hallucinations, probably secondary to medication for Parkinson's. Not troublesome recently. Scored 23/29 on MMSE. No acute mental health problem. Did not require admission.*	Correspondence	126	
		Clinical notes	62	
	Dr Lord: Cunningham should attend Dolphin Day Hospital once a week. Extremely dystonic and lost a lot of weight. Tests to be carried out.	Correspondence	342	

6/7/98	Reviewed at GWMH. *Re-referral via GP after DV. ↓ mobility/dystonia. ↓ weight. Problems with moving out of flat with its adaptations. Now at Alverstoke House. Plan: Investigate weight loss, ↓ L-dopa, treat constipation. On examination: Mask-like face, left hand tremor – not dystomic at 12 noon. Obvious weight loss since last seen. Said eating poorly until recently, but better now.*	Clinical notes	637	
		Nursing notes	898	
7/7/98	Reviewed at Alverstoke House Nursing Home. Code A *Settled in well. Low in mood. Appetite reasonably good, although significant weight loss in last months. Constipated. Anxious re future. Clean and tidy in appearance. Talkative. Mobility very limited. Moves short distances with frame. Often needs help transferring from chair to bed. Felt Cunningham was clinically depressed and would benefit from anti-depressant. Prescribed sertraline.*	Correspondence	118	

		Correspondence Clinical notes	44 61	
9/7/98	Reviewed at Dolphin Day Hospital. *Low in mood, having a bad day. In wheelchair. Commenced on sertraline as requested.*	Nursing notes	899	
20/7/98	Reviewed by Dr Lord at Dolphin Day Hospital. *Parkinson's and transfers stable overall. Able to transfer with one. Stability not deteriorated too much. Weight even lower at 67.2kg. Low in mood. Short-term memory much worse. Dysphonic. Tremors in left uppoer limb, more than right. No dystonia. Denies hallucinations now. Mentioned difficulty swallowing, but able to feed himself and usually finishes main meal and pudding. Meds to continue. Speech and Language Therapist to assess swallow. To be admitted to Mulberry Ward on 21/7/98.*	Correspondence	112	

		Clinical notes Nursing notes	639-640 900	
21/7/98	Informal admission to Mulberry Ward, GWMH. Discharged to Thalassa Nursing Home on 29/8/98. *Transferred to Mulberry Ward for assessment. Diagnosis: Parkinson's Disease and dementia, depressive episode, mylodysplasia. Prognosis: Poor. Low in mood and irritable on admission. Distressed by lack of mobility and independence. Behaviour at times very difficult. Sertraline stopped. Carbamazepine introduced. Had regular reviews by Dr Lord. Mylodysplasia remained stable. Needed to be catheterised for urinary retention. Placement found at Thalassa Nursing Home.*	Discharge summary	465-466	
	27/8/98: Review by Dr Lord: Catheterised for retention of urine. Denies constipation. Eating better. Weight improved to 69.7kg. Much better in mood. Parkinson's a little worse. Takes 1 or 2 people to transfer. Not really mobile. Not keen to increase Levodopa.			

		Clinical notes Correspondence Discharge checklist Admission checklist Nursing notes	66-93 98, 106 234 240 900	
17/9/98	Reviewed at Dolphin Day Hospital. Infection to sores diagnosed. Metronidazole prescribed. **Code A**: *A little brighter than couple of months ago. Weight steady at 68.6kg. Not eating too badly, sleeping reasonably. Some increase in stiffness, probably due to anti-psychotic medication. Sinemet increased. Cunningham still harping on about placement at RAF home. To be seen by occupational therapist re adaptations.*	Correspondence	460, 463	

	Attended DDH. OT will order wheelchair. Wound swab results positive. Commenced oral metronidazole. Pressure sore exuding ++ - not redress due to ↓ compliance from Cunningham. Would not wake after a rest on bed. Refusing to talk, drink, swallow medication. Expressing a wish to die. SB Dr Lord – may possibly admit on Monday when reviewed.	Nursing notes	902	
	The results of the swab to the sores on your bottom show that you have an infection in it.	Correspondence	318	
21/9/98	Reviewed by Dr Lord at Dolphin Day Hospital, in respect of sacral ulcer. Admitted to Dryad Ward, GWMH. *Reviewed in DDH today. Has large necrotic sacral ulcer, extremely offensive. Some grazing of skin around necrotic area, also reddened area with black centre on left lateral malleolus. Parkinson's no worse. Mentally less depressed but continues to be very frail. Admitted to Dryad Ward with a view to more aggressive treatment on the sacral ulcer as I feel this will now need aserbine in the first instance. Social worker to keep open place at Thalassa Nursing Home.*	Correspondence	458	

	Dr Lord: DDH. BP 110/70. Very frail. Tablets found in mouth – some hrs after they're given. Offensive large necrotic sacral ulcer with thick black scar. Left lateral malleous – small black scar and reddened. PD no worse. *Diagnosis: (1) Sacral sore (2) PD (3) Old back injury (4) Depression and element of dementia (5) Diabetes mellitus – diet (6) Catheter for retention.* *Plan: (1) Stop codanthramer + metronidazole + [unclear] (2) Dryad today, aserbine for sacral ulcer, nurse on site, high protein diet, oramorph prn if pain (3) N/Home to keep bed open for next 3/52 at least (4) Patient informed of admission – agrees (5) Inform N/Home,* Code A *+ social worker. Prognosis poor.*	Clinical notes	645	
	S/B Dr Lord. Pressure sore looks worse although NH felt it had improved. Plan: Admit Dryad Ward for treatment of pressure area. Ask Thalassa to keep bed for 2/3 weeks at least. Plan of care for ward written in med notes by Dr Lord.	Nursing notes	903	

	Reviewed by Dr Barton. *Transfer to Dryad Ward. Make comfortable. Give adequate analgesia. Happy for nursing staff to confirm death.*	Clinical notes	647	
	Admitted from DDH with history of Parkinson's, dementia and diabetes. Large necrotic sore on sacrum. S/B Dr Barton. Back pain from old spinal injury. *14.50: Oramorph 5mg given prior to wound dressing.*	Significant events	861	
	Driver commenced at 23.10 containing diamorphine 20mg and midazolam 20mg. Slept soundly following. BS at 23.20. 2 glasses of milk taken when awake. Much calmer this am. Sacral sore oozing but left exposed as requested.	Nursing care plan	870	

	Requires assistance to settle for the night (p869). *Waterlow score – 20 (p871).* *Shaw: Large sacral sore present on admission. Desired outsome: Aim to promote healing and prevent further breakdown (p873).* *Dressing applied to left buttock @18.30. Aserbine cream to black necrotic area + zinc + castor oil to surrounding skin. Very agitated at 17.30. Oramorph 10mg/5ml @20.20. Pulled of dressing to sacrum (p874).* *Shaw: Catheterised on admission (p879).*	Nursing care plan	869-880	
	Drug charts indicate: • Oramorph: Dr Lord prescribes 2.5-10mg PRN. 5mg administered at 14.15. 10mg administered at 20.15. • Diamorphine: Dr Barton prescribes 20-200mg/24hrs PRN by subcutaneous infusion (in daily review prescriptions, but marked PRN). 20mg/24hrs administered at 23.10. • Midazolam: Dr Barton prescribes 20-80mg/24hrs PRN by subcutaneous infusion (in daily review prescriptions, but marked PRN). 20mg/24hrs administered at 23.10. • Hyoscine: Dr Barton prescribes 200-800µg/24hrs PRN by subcutaneous infusion (in daily review prescriptions, but marked PRN).	Drug charts	754, 758	

22/9/98	*Hallman: Mr Farthing has telephoned. Explained that syringe driver commenced yesterday evening for pain relief and to allay his anxiety following episode when Arthur tried to wipe sputum on a nurse saying he had HIV. Also tried to remove catheter and removed sacral dressing, took of his covers and exposed himself.* *Later: Syringe driver charged at 20.20. Contains diamorphine 20mg and midazolam 20mg. Appears less agitated this evening.*	Significant events	861-862	
	Driver running as per chart. Very settled night. B/S 5 @ 06.00 (p870). *23.00: Dressing came off. Reapplied (p874).* *Shaw: Requires assistance with personal hygiene due to Parkinson's disease. Action: Daily bed bath/bath/shave...report any changes in skin condition (p877).*	Nursing care plan	869-880	
	Drug charts indicate: • Diamorphine: 20mg/24hrs administered at 20.29. • Midazolam: 20mg/24hrs administered at 20.20.	Drug charts	758	

23/9/98	Reviewed by Dr Barton. *Hallman: S/B Dr Barton. Has become chesty overnight. To have hyoscine added to driver. Stepson contacted and informed of deterioration. Mr Farthing asked if this was due to commencement of syringe driver. Informed that Cunningham on small dosage which he needed.*	Significant events	862	
	Became a little agitated at 23.00, syringe driver boosted with effect. Seems in some discomfort when moved. Driver boosted prior to position changing. Sounds chesty this morning. Catheter draining, urine very concentrated.	Nursing care plan	870	
	Drug charts indicate: • Diamorphine: 20mg/24hrs administered at 09.25, then discarded. 20mg/24hrs administered at 20.00. • Midazolam: 20mg/24hrs administered at 09.25, then discarded. 60mg/24hrs administered at 20.00. • Hyoscine: 400µg/24hrs administered at 09.25, then discarded. 400µg/24hrs administered at 20.00.	Drug charts	758	

24/9/98	Reviewed by Dr Barton. *Remains unwell. Son has visited again today and is aware of how unwell he is. sc analgesia is controlling pain just. Happy for nursing staff to confirm death.*	Clinical notes	645	
	CPN: Physical decline, pressure sore's developed, admitted to Dryad Ward. He is terminally ill & not expected to live past the W/E according to sister on ward.	CPN notes	94	
	Hamblin: Report from night staff that Brian was in pain when being attended to, also in pain with day staff, especially his knees. Syringe driver renewed at 10.55 with diamorphine 40mg, midazolam 80mg and hyoscine 800mcgm. Dressing renewed this afternoon. Mr Farthing seen by Dr Barton this afternoon and is fully aware of Brian's condition. In the event of death Brian is for cremation.	Significant events	863	

	All care given. Nursed from side to side. Peaceful night's sleep. Syringe driver running. Starting to sound chesty this morning.	Nursing care plan	870	
	Drug charts indicate: • Diamorphine: 40mg/24hrs administered at 10.55. Then increased: 60mg/24hrs administered – time unclear. • Midazolam: 80mg/24hrs administered at 10.55. • Hyoscine: 800µg/24hrs administered at 10.55.	Drug charts	758	
25/9/98	*All care given this am. Driver recharged at 10.15 – diamorphine 60mg, midazolam 80mg, hyoscine 1200mcg. Son present.*	Significant events	863	
	Remains very poorly. On syringe driver. For TLC.	Clinical notes	647	

	Peaceful night. Position changed [unclear].	Nursing care plan	870	
	Drug charts indicate: • Diamorphine: Dr Barton prescribes 40-200mg/24hrs by subcutaneous infusion. 60mg/24hrs administered at 10.15. • Midazolam: Dr Barton prescribes 20-200mg/24hrs by subcutaneous infusion. 80mg/24hrs administered at 10.15. • Hyoscine: Dr Barton prescribes 800µg-2mg/24hrs by subcutaneous infusion. 1200µg/24hrs administered at 10.15.	Drug charts	758, 831	
26/9/98	*Condition appears to be deteriorating slowly. All care given. Sacral sore redressed. Mouthcare given. Driver recharged at 11.50.*	Drug charts	863 869-880	

	Drug charts indicate: • Diamorphine: 80mg/24hrs administered at 11.50. • Midazolam: 100mg/24hrs administered at 11.50. • Hyoscine: 1200µg/24hrs administered at 11.50.	Drug charts	758, 831	
	Continues to deteriorate.	Clinical notes Nursing care plan	647 870	
	Death recorded at 23.15.	Significant events	864	
	Cause of death: (I) Bronchopneumonia (II) Parkinson's Disease, Sacral Ulcer	Death certificate		

GMC – v – DR JANE BARTON

CHRONOLOGY: PATIENT K – ELSIE DEVINE

Date of Birth: 26/6/11

Date:	Event:	Source:	Page(s):	Comments:
1/4/99	Reviewed in clinic of Dr Logan, consultant geriatrician. *Dr Ravindrane: Diagnosis: Nephrotic syndrome ?myeloma. Complaining of swelling of feet. Blood test shows high ESR, renal impairment, low protein. Not complaining of anything apart from swelling of legs. Urine showed +++protein. Blood pressure 150/90. Comfortable. Chest clear.*	Correspondence	81	
		Clinical notes	145-147	

15/4/99	Reviewed in clinic of Dr Logan. *Referred to Dr Cranfield. Patient moderately frail. Very bright mentally. Peripheral oedema and hypoalbuminaemia. Has nephritic syndrome and paraproteinaemia. Not sure whether has myeloma.*	Correspondence	89	
29/4/99	Radiology report on chest and skeletal survey. *No evidence of myeloma or any other focal bone abnormality.*	Report	383	
13/5/99	Examined by Dr Cranfield, consultant haematologist, including examination of skeleton system. *Diagnosis: Nephrotic syndrome, IgA lambda paraprotein. Her only complaint is bilateral leg oedema. No other evidence to suggest multiple myeloma. Bone marrow test performed.*	Correspondence	75	
		Clinical notes	144	

2/6/99	Reviewed by Dr Cranfield. *Insufficient evidence of myeloma or lymphoma. Both kidneys small on ultrasound. Reluctant to offer chemotherapy. Referred to renal unit.*	Correspondence	65-73	
8/6/99	Reviewed by Dr Stevens, consultant renal physician, at request of Dr Cranfield. *Albumin of 20, creatinine of 160. 3+ protein on urine analysis. Creatinine level of 160 only a little higher than I would normally expect at her age. Likely to be long-standing glomerulonephritis rather than a new problem. Steroids unlikely to help. Preference is to treat her conservatively.*	Correspondence	61, 63	
		Clinical notes	152	
20/7/99	Reviewed by SHO to Dr Stevens. *Remains well on current treatment with no new problems. Creatinine slowly worsening – 192 on test sample. Albumin low. Symptomatic treatment only.*	Correspondence Clinical notes	53 153	

28/7/99	Reviewed by Dr Cranfield. *Looking much better. Leg oedema better controlled. No significant deterioration in renal function. Some tenderness and discomfort over sacrum. Not keen to start aggressive treatment. Keep steroids in reserve.*	Correspondence	51	
7/9/99	Reviewed by Dr Cranfield. *Oedema marked up to knees.*	Correspondence	41	
		Clinical notes	154	
9/10/99	Admitted to Queen Alexandra Hospital with episode of acute confusion. *Confused, aggressive and wandering. Diagnosis: Multi-infarct dementia, CRF.*	Discharge summary	25	

		Care plan Correspondence Nursing notes	32 39 159	
14/10/99	Reviewed by Dr Taylor, clinical assistant in old age psychiatry. *Remains confused and disorientated but no longer aggressive or difficult in behaviour. Sleeping better. On examination, calm and cooperative. Speech normal. Denied feeling unhappy. 9/30 on MMSE. Very deaf. Diagnosis: Dementia. Recommend referral to social services for residential care.*	Correspondence	29-30	
		Nursing notes Patient assessment Correspondence	164-165 395-404 411	
15/10/99	Discussion with Dr Smith, GP. Plan to transfer patient to St Christopher's.	Nursing notes Care plan	165-167 173	

19/10/99	Reviewed by Dr Jayawardena, consultant geriatrician. Transfer arranged to GWMH. *Moderate chronic renal failure. Admitted with history of UTI. Quite alert. Can stand. Rather unsteady on walking. Chest clear. No evidence of cardiac failure. Suitable for a rehabilitation programme. Will arrange transfer to GWMH.*	Correspondence	21	
		Nursing notes	169-172	
21/10/99	Transferred to Dryad Ward, GWMH. Reviewed by Dr Barton. *Transfer to Dryad Ward continuing care. Admitted to Mulberry, acute confusion. PMH: Dementia, myeloma, hypothyroidism. Transfers with one, so far continent, needs some help with ADL, MMSE 9/30, Barthel 8. Probably for rest home in due course.*	Clinical notes	155	

	Needs minimal assistance with ADLs. Very pleasant lady. Appetite not good. Can be a little unsteady on feet. Both feet swollen. Seen by Dr Barton.	Significant events	223	
		Transfer letter Care plan	23 190	
	Drug charts indicate: • Thyroxine: Dr Barton prescribes 100µg od. Administered from 22/10/99 to 17/11/99. Not administered on 2/11/99 or from 18/11/99. • Frusemide: Dr Barton prescribes 40mg od. Administered from 22/10/99 to 17/11/99. Not administered from 18/11/99. • Temazepam: Dr Barton prescribes 10mg nocte PRN. • Oramorph: Dr Barton prescribes 2.5-5ml (5-10mg) PRN. Not administered.	Drug charts	279	

Unclear	Drug charts indicate: • Chlorpromazine: Dr Barton prescribes 50mg im. Administered at 08.30.	Drug charts	279	
25/10/99	Reviewed by Dr Reid, consultant geriatrician. *Mobile unaided. Dresses self. Continent. BP 110/70. Chronic renal failure.*	Clinical notes	155	
		Care plan Significant events	186 223	
1/11/99	Reviewed by Dr Reid. *Physically independent but needs supervision of washing and dressing, help with bathing. Continent. Quite confused and disorientated. Unlikely to get much social support at home, therefore try home visit to see if functions better in own home.*	Clinical notes	156	

		Significant events	223	
	Drug charts indicate: • Amiloride: Dr Barton prescribes 5mg od. Administered from 2/11/99 to 18/11/99. Not administered from 19/11/99.	Drug charts	279	
11/11/99	Drug charts indicate: • Temazepam: 10mg nocte administered. • Trimethoprim: Dr Barton prescribes 200mg bd. Administered from 11/11/99 to 15/11/99. Not administered from 16/11/99. • Thioridazine: Dr Barton prescribes 10mg tds PRN. Administered at 08.30.	Drug charts	279	
		Care plan	190	

12/11/99	Drug charts indicate: • Thioridazine: 10mg administered at 13.20.	Drug charts	279	
		Contact record	229	
13/11/99	Drug charts indicate: • Thioridazine: 10mg administered at 08.25 and 18.00.	Drug charts	279	
14/11/99	Drug charts indicate: • Thioridazine: 10mg administered at 08.25 and 19.45.	Drug charts	279	
		Care plan	190	

15/11/99	Seen by Dr Reid. Request for review by Dr Lusznat. *Very aggressive at times. Very restless. Ask Dr Lusznat to see.*	Clinical notes	156	
		Care plan Significant events	190 223	
	Drug charts indicate: • Thioridazine: 10mg administered at 08.30 and 21.30.	Drug charts	279	
16/11/99	Referral to Dr Lusznat by Dr Barton. *Using thioridazine. Renal function ↓ MSU showed no growth.*	Clinical notes	156	
	Slept well, out once in night. Refused medication in	Care plan	195	

	morning.			
	Drug charts indicate: • Thioridazine: 10mg administered at 08.45.	Drug charts	279	
17/11/99	Drug charts indicate: • Thioridazine: 10mg administered at 17.40.	Drug charts	279	
	Slept well. Out to toilet twice. Thioridazine not required.	Care plan	195	
18/11/99	Reviewed by Dr Taylor. *Reviewed on ward. Happy, no complaints. Plan: Transfer to Mulberry when bed available. Physical condition stable.*	Clinical notes	157, 407	

	Drug charts indicate: • Fentanyl: Dr Barton prescribes 25 skin patch (every three days). Administered at 09.15.	Drug charts	279	
19/11/99	Reviewed by Dr Barton. *Marked deterioration overnight. Confused, aggressive. Creatinine 350 (or 360). Fentanyl patch commenced yesterday. Today further deterioration in general condition. Needs SC analgesia with midazolam. Son seen and aware of condition and diagnosis. Please make comfortable. Happy for nursing staff to confirm death.*	Clinical notes	157	
	Marked deterioration over last 24 hours. Extremely aggressive this am. Refusing all help from staff. Chlorpromazine 50mg given IM at 08.30. Syringe driver commenced at 09.25. Fentanyl patch removed. Son seen by Dr Barton at 13.00, situation explained. *20.00: Daughter has visited – seen by Dr Barton. All care given to Elsie.* *Nocte: Peaceful night. Syringe driver satisfactory.*	Significant events	223-224	

	Elsie had a peaceful night. Syringe driver satisfactory.	Care plan	195	
	Social services informed to close the case. Mulberry ward also informed.	Contact record	230	
	Drug charts indicate: • Chlorpromazine: Dr Barton prescribes 50mg by injection at 08.30. Administered. • Diamorphine: Dr Barton prescribes 40-80mg/24hrs by subcutaneous infusion. 40mg/24hrs administered at 09.25. • Midazolam: Dr Barton prescribes 40-80mg/24hrs by subcutaneous infusion. 40mg/24hrs administered at 09.25.	Drug charts	279B, 281	
20/11/99	Drug charts indicate: • Diamorphine: 40mg/24hrs administered. • Midazolam: 40mg/24hrs administered.	Drug charts	281	

		Care plan Significant events	195 224	
21/11/99	Drug charts indicate: • Diamorphine: 40mg/24hrs administered. • Midazolam: 40mg/24hrs administered.	Drug charts	281	
		Significant events	224	
	Death recorded at 20.30.	Clinical notes Significant events	157 224	
	Cause of death: Chronic renal failure.	Death certificate		

GMC – v – Code A

CHRONOLOGY: PATIENT F – Code A

Date of Birth: Code A

Date:	Event:	Source:	Page(s):	Comments:
23/1/98	Reviewed by Code A consultant dermatologist.	Clinical notes Correspondence	231 236, 240-241	
27/4/98	Assessed by Code A consultant rheumatologist. Possible diagnosis of CREST syndrome.	Correspondence	352	
29/6/98	Admitted from home for treatment of leg ulcers.	Clinical notes Significant events Care plan	74-77 300-301 306	

5/8/98	Admitted to Royal Hospital Haslar, following fall at home and fractured left neck of femur. Undergoes surgery – left cemented hemi-arthroplasty. *Previously well. 84. Fell this am. Fractured neck of femur. PMH: MI 3 yrs ago. No residual angina. °DM °COAD °Hypertension. No chest pain. Walks 100yds (stops due to arthritis). Lives alone. Mobile, independent and self-caring. Plan: Consent, theatre, hemiarthroplasty, IV fluids.*	Clinical notes	495	
	Fell over at 10.00. c/o pain L hip – shortened and externally rotated. Fractured neck of femur. Unable to weight bear.	A&E notes	445-447	
	Returned from theatre safely. Has taken fluids and passed urine post-operatively. Compression bandages in situ for leg ulcers. For x-ray and bloods tomorrow morning and then to mobilise when comfortable.	Nursing notes	604	

		Transfer letter Operation notes Care plan Drug charts	23-25 500 563-565 567-574	
6/8/98	Reviewed by physiotherapist and HO. *Lives alone, previously independent + self-caring. Previously only able to walk approx 100yds before rest due to arthritis. Awaiting chest x-ray. Currently unwell. R/V mane.*	Physio notes	460	
	Vomiting. No bowel movement. No abdo tenderness. SOB. Denies pain or discomfort. Chest – bilateral fine basal crackles. Imp – (1) Fluid overload – LVF (2) Infection. Stop ivi for 8hrs. Start augmentin.	Clinical notes	503-504	
	Fully-assisted bed bath this morning. Commenced on analgesia to wean her off PCA. Leg bandages for ulcers. IV fluids continue.	Nursing notes	604-605	

7/8/98	Reviewed by physiotherapist and HO. *CXR – OK. Mobilised bed → chair with frame + 2 – managed v well with encouragement.*	Physio notes	460	
	Looks better today. Awaiting report hip x-ray. *Bilateral chest crackles.*	Clinical notes	505-506	
	Remains on bed-rest until after x-ray this morning. Assisted bed bath. Oxygen saturation remains at 93-94% on air, so oxygen discontinued. *19.00: IV fluids have been stopped. Became breathless on movement from commode to bed. Given some oxygen.* *Nocte: Awakes frequently throughout night. Frusemide given IV with good effect. Bed bath in morning. Open area noted in crease of buttock – surrounding area appears fragile. Analgesia given x 1 with effect.*	Nursing notes	605-606	

8/8/98	Reviewed by HO. *Reduced urine output. Bilateral basal crackles. To give frusemide. Monitor urine output.*	Clinical notes	507	
	All care given. Assisted wash. Remains very breathless. Pressure areas poor. Sacrum broken in sacral crease. Waterlow 29+. Sat out for half an hour. Mobility poor. Unable to tolerate nursing on side. Poor fluid intake. Paracetamol given for pyrexia. Agitated at times. Cyclizine given.	Nursing notes	606-607	
9/8/98	Reviewed by SHO. *Urine output much improved post-diuretic. Problems: Poor mobility, SOB, diarrhoea.*	Clinical notes	507-508	
	Full bed bath. IV fluids recommenced. Fluid and diet intake remain minimum. Walked around bed with zimmer frame and assistance. Sat out for one hour. Unable to tolerate nursing on side, always rolls onto back. Hip dressing changed.	Nursing notes	608	

10/8/98	Reviewed. Blood tests conducted. *Physio: Appears unwell today. ?MI ?chest infection. R/V mane. Mobilise as able.*	Physio notes	460	
	Patient unwell. Vomiting/diarrhoea, drowsy, denies pain, orientated. Apyrexial. Chest clear. Sats on air 94%. Plan: ECG, continue IV fluids. *ECG: Sinus tachycardia.* *14.30: Much improved, alert, bright and orientated.* *CXR – chest infection. On augmentin.*	Clinical notes	509-512	
	Restless night (9^{th}-10^{th}). Temazepam given but vomited up. Bottom red and tender. Sudacrem applied. Diarrhoea overnight. All care given in morning. Area between buttocks moist and broken. Antibiotics changed to IV as unable to swallow large tablets. Ate small amount of ice cream. Ulcers need redressing – both legs. Very unsettled night (10^{th}-11^{th}). Incontinent of faeces. Able to move and turn on bed. Sacral area remains red.	Nursing notes	608-609	

		Blood test results	552	
11/8/98	Reviewed by physiotherapist and HO. *Remains unwell. L base remains quiet. Good cough.*	Physio notes	460	
	Pt feeling nauseous + abdo pain. Plan further IV dextrose, cyclizine. *Later: Much improved, apyrexial, good urine output. Chest: Good expansion R = L. Plan: Switch to oral augmentin, encourage fluids, Ensure.* *11.30pm: Urine output↓ Plan: Stop IV fluids, give IV frusemide. CXR tomorrow.*	Clinical notes	512-514	
	11.20: Full wash this morning. Bottom and sacral area very red and breaking down in cleft. Incontinent of faeces. Complained of stomach pain this morning. IV dextrose commenced. Cyclizine given. Tolerated v little food. Much better at time of report. *19.30: Remains very sleepy. To encourage oral fluids. Urine output satisfactory.*	Nursing notes	609-610	

12/8/98	Reviewed by SHO. *Much improved. Has sat out today. Developing sacral bed sore. U+Es improving. Plan: Mobilise with physiom encourage oral fluids, stop augmentin, no IV fluids.*	Clinical notes	514-515	
	Fair morning. Sat out for one hour. Bottom remains extremely red. Fluids taken in reasonable amounts. Ulcers redressed. New bed arrived. 1 episode of diarrhoea , no other problems, appears a lot brighter.	Nursing notes	610	
13/8/98	Referred to Code A consultant geriatrician. *Assess this lady re future management. Over last two days she has been alert and well, now our intention to work on her mobilisation. Previously lived in ground floor house. Physio has visited for past 6 weeks.*	Clinical notes	515	

	Reviewed by Code A *Hemiarthroplasty on 5/8/98. Catheterised. Diarrhoea and vomiting have been problems. Appetite poor. Eating and drinking very small amounts. ECGs show atrial fibrillation. Ischaemic heart disease and LVF have been problems recently. Still dehydrated, hypokalaemic and has normochromic anaemia. Problems with chronic leg ulcers and recently buttock ulcers. Overall she is frail and quite unwell at present. Happy to arrange transfer to continuing care bed at GWMH. Uncertain as to whether there will be a significant improvement.*	Correspondence	26-27	
		Clinical notes (Code A	516-517	
	Physio: Unable to mobilise at present due to chest pain.	Physio notes	461	

	Unsettled night overnight. Continues to be very restless. Fluid intake improved. *AM: Pressure areas remain red. c/o central chest pain. GTN spray given. Reviewed by doctor, no further action required.* *PM: Comfortable afternoon. Oral fluids taken. No c/o chest pain. For transfer to GWMH next week.*	Nursing notes	611	
14/8/98	Reviewed by physiotherapist and on ward round. *Physio: Brighter today. Sitting out. Walked short distance with frame + 1 – managed very well. To gradually ↑ distance walked as energy increases.*	Physio notes	461	
	Ruby spent a comfortable night. Turned frequently to rest sacrum. Fluid intake satisfactory. *AM: Has had a wash with minimal assistance. No chest pain. Walked with physio into middle of ward with minimal assistance.*	Nursing notes	611	

	Well. Has stood with frame. Plan: Mobilise. → GWMH next week.	Clinical notes	517	
15/8/98	Reviewed by SHO and HO. Codeine phosphate prescribed. *L sided chest pain in ribs through to back – since being manhandled. ECG – nil change, no effect with GTN. Imp: Muscular-skeletal pain, consider [unclear] or angina. Plan: (1) Analgesia codeine phosphate (2) [Unclear] (3) Consider spinal CT or VQ or pulmonary angiography.*	Clinical notes	518	
	07.00: Some pain due to arthritis in left shoulder overnight. Had paracetamol to good effect. Frequently assisted to turn and move up the bed to make her comfortable. Fully alert. *AM: Full assistance given with hygiene. Sacrum broken on both left and right buttocks + sacral cleft. Dressing applied. Sat out in chair for lunch. Now back to bed. Hip would clean. c/o pain in left shoulder/chest on inspiration.*	Nursing notes	612	

17/8/98	Reviewed by SHO. *Well. ° chest pain. Mobilising slowly. Awaiting transfer to GWMH.*	Clinical notes	519	
	Bright – sitting out in chair. Indep sit→st. Mob with ZF + supervision – managed well.	Physio notes	461	
	Had quite a good night's sleep after settling late and frequently calling out. Taking good amounts of oral fluids. Bowels satisfactory. *20.15: Seemed confused this afternoon, reluctant to move herself from bed. Pyrexial at 38.8°C at 19.45. Paracetamol given.*	Nursing notes	613-614	
		Drug charts	617-618	

18/8/98	Reviewed by SHO at Royal Hospital Haslar. *Well, comfortable and happy. Last pm spike temp, now 37.3°. Mobilising well. →GWMH today.*	Clinical notes	519	
	02.00: Increased shortness of breath. Recommenced on oxygen therapy. Encouraged to expectorate. Apyrexial. Sacral dressings changed.	Nursing notes	614	
	Transferred to Dryad Ward, GWMH. *Has had a slow recovery, exacerbated by bouts of angina and breathlessness. This appeared to be secondary to fluid overload, now resolved. Presently she is slowly mobile with zimmer frame and supervision. Able to wash top half independently but requires help to wash back and bottom. Bilateral leg ulcers redressed very 4-5 days. Has broken area on left buttock and in cleft of buttocks – improving. Has small appetite, oral fluids need encouraging. Urinary catheter in situ. Diarrhoea resolved. Usually lucid, only very occasionally seems confused at night. Hearing aid appears to have gone missing.*	Transfer letter	23	

	Reviewed by Dr Barton. *Transfer to Dryad Ward continuing care. HPC: Fracture n o femur L 5-8-98. PMH: Angina, CCF. Catheterised. Transfers with 2. Needs some help with ADL. Barthel 6. Get to know. Gentle rehabilitation. Happy for nursing staff to confirm death.*	Clinical notes	78	
	Barrett: Communicates well. Compliance: Yes. Pain: Yes. Skin: Leg ulcers and sacral pressure sore (p387). *Collins: Settled and slept well 22.00 until midnight. Woke very distressed & anxious, says she needs someone with her. Oramorph 10mg given 00.15 with little effect. Very anxious during the night. Confused at times (p388).* *Patient's understanding of condition: To mobilise slowly and feel better all round. Diet normal. Appetite poor, needs encouragement (p392).*	Nursing care plan	374-393	

	Slow post-op recovery. Leg ulcers on both legs. Break on sacrum. For slow mobilisation. Catheterised. Pleasant lady, happy to be here. Complexion pale, skin dry. MI 3 years ago. Renal failure 1993. *PM: Seems to have settled quite well. Fairly cheerful this pm.*	Significant events	394	
	Drug charts indicate: • Oramorph: Dr Barton prescribes 2.5-5ml (5-10mg) PRN. 5mg administered at 14.15. • Temazepam: Dr Barton prescribes 10-20mg PRN. Not administered. • Also prescribed: Digoxin, Slow K, Bumetanide, Allopurinol.	Drug charts	369	
Undated	Drug charts indicate: • Diamorphine: Dr Barton prescribes 20-200mg/24hrs by subcutaneous infusion. • Hyoscine: Dr Barton prescribes 200-800µg/24hrs by subcutaneous inifusion. • Midazolam: Dr Barton prescribes 20-80mg/24hrs by subcutaneous infusion.	Drug charts	368	

19/8/98	Code A *11.50: c/o chest pain, not radiating down arm – no worse on exertion, pulse 96, grey around mouth. Oramorph 10mg given. Doctor notified. Pain only relieved for short period – very anxious. Diamorphine 20mg midazolam 20mg commenced in syringe driver.*	Significant events	394	
	Drug charts indicate: • Oramorph: 10mg administered at 00.15 and 11.50. • Diamorphine: 20mg/24hrs administered at 16.00. • Midazolam: 20mg/24hrs administered at 16.00.	Drug charts	368-369	
20/8/98	*12.15: Condition appears to have deteriorated overnight. Driver recharged 10.10. Family informed of condition.* *Night: General condition continues to deteriorate. Very bubbly. Suction attempted without success. Position changed frequently. Only rousable and distressed when moved. Syringe driver recharged at 07.35 (on 21st).*	Significant events	394	
		Nursing care plan	374-393	

	Drug charts indicate: • Diamorphine: 20mg/24hrs administered. • Midazolam: 20mg/24hrs administered at 09.15. Increased to 40mg/24hrs at 10.15. • Hyoscine: 400µg/24hrs administered at 09.15. Increased to 800µg/24hrs at 10.50.	Drug charts	368	
21/8/98	Drug charts indicate: • Diamorphine: 60mg/24hrs administered at 07.35. • Midazolam: 60mg/24hrs administered at 07.35. • Hyoscine: 800µg/24hrs administered at 07.35.	Drug charts	368	
	Condition continued to deteriorate slowly. All care continued. Family present all afternoon.	Significant events	395	
	Death recorded at 18.25.	Clinical notes Significant events	78 395	

	Cause of death: Bronchopneumonia.	Death certificate		

GMC – v – DR JANE BARTON

CHRONOLOGY: PATIENT B – ELSIE LAVENDER

Date of Birth: Code A

Date:	Event:	Source:	Page(s):	Comments:
11/3/95	Admitted to Royal Hospital Haslar, following a collapse. Discharged on 31/3/95.	Haslar notes Correspondence	32-46, 464-488 73	
5/2/96	Admitted to Royal Hospital Haslar, following a fall. X-rays conducted of skull and shoulders. *Admitted via Casualty having suffered a fall on 5/2/96. Known to suffer from insulin-dependent diabetes. Had multiple bruising but no fractures.*	Correspondence	61	
		A&E notes Clinical notes	124-134 136-142	

6/2/96	Temperature developed. Commenced on amoxicillin (antibiotic). *Talking, alert and orientated. Cannot remember yesterday's events. Complaining of pain in right arm. Tender over humerus. Bilateral hand swelling. Hips seen OK. Chest clear. Plan: Social work involvement, OT assessment.* *Later: Temp 38.5°. Start amoxicillin.*	Clinical notes	142-143	
	Prescribed coproxamol and dihydrocodeine. Administered until transfer to GWMH.	Drug charts	669, 675	
		Nursing notes	642-644	
8/2/96	Seen by Code A physiotherapist. *C/O shoulder tenderness and abdo pain. No voluntary movement on request due to bilat shoulder pain. Sitting to standing with 2. Full support required for a few steps. Pain in shoulders seems to be major problem.* *Later: For analgesia – shoulders painful.*	Clinical notes	146	

	Very high risk on Waterlow score. Poor mobility due to fall. Shoulders very painful. Action: Give analgesia as prescribed by doctor regularly. Encourage Mrs Lavender to do as much as she can for herself. Assist with feeding as she has difficulty eating. *Regular analgesia given with poor effect. S/B physio, walked two steps. Pressure areas intact.*	Nursing notes	639, 643	
9/2/96	Ward round by SHO. *Feeling better but still c/o pain in arms/shoulders.*	Clinical notes	147	
12/2/96	*Shoulders still very painful.*	Clinical notes	147	
13/2/96	Referred to Dr Lord, consultant geriatrician. *Over the time on the ward, has been slow to mobilise, needs help to walk, dress, feed and wash. Barthel score 5. Reluctant to go into a home, but feels she cannot go home in present condition. Diabetes now under control. Not sure how mobile she really is, as does not seem able to do anything for herself.*	Clinical notes	147-149	

		Nursing notes	637-643	
14/2/96	Ward round by SHO. *Still not able to do much for herself because of "pain in arms."*	Clinical notes	150	
16/2/96	Seen by Dr Tandy, consultant geriatrician. Transfer recommended to Daedalus Ward, GWMH. *Since the fall, patient has had weakness in both hands and has been unable to stand. Complains of pain across shoulders and down arms. She feels mobility starting to improve in her hands and she stood with physios. Still requires 2 to transfer. Has no problems eating or drinking. Long-standing stress incontinence. Denies any other problems. Examination confirmed atrial fibrillation. Does have weakness in hands. Most likely problem is brain stem stroke leading to fall. Might want to consider aspirin. I'll get her over to Daedalus Ward for rehab as soon as possible.*	Correspondence	242, 244	

		Clinical notes Nursing notes	151-153 642-648	
20/2/96	Reviewed by physiotherapist. Seen by SHO on ward round. *Requires encouragement to mobilise. Function improving. Starting to feed herself with encouragement. For OT assessment today. Still c/o shoulder pain. Mobility remains poor. Sitting to standing with 2. Standing balance poor. Discharge to own home seems unlikely in near future.*	Clinical notes	154-155	
		Nursing notes	645-646	

21/2/96	Nursing referral made to Daedalus Ward, GWMH. *Insulin-dependent diabetic. Almost no adverse effects from the head injury. Main problem now immobility. Has pain in arms and shoulders, needs encouragement to use them. Able to mobilise from bed to chair with two nurses. Has stress incontinence on standing or mobilising.* *Needs minimal assistance with feeding, full assistance with hygiene needs. Ulcers to both legs dressed every other day. All pressure areas intact although buttocks very red.*	Nursing referral form	1001	
22/2/96	Transferred to Daedalus Ward, GWMH, under Dr Lord. Reviewed by Dr Barton. *Fell at home top to bottom of stairs. Lacerations on head. Leg ulcers. Severe incontinence. Needs a catheter. Insulin dependent. Transfers with 2. Help to feed and dress. Barthel 2. Assess general mobility. Possible for rest home if home found for cat.*	Clinical notes	975	

	Probable brain stem CVA on 5/2/96. Problems with grip in both hands. Experiences pain in arms and shoulders. Can transfer with 2. Seen by Dr Barton. Catheterised. Leg ulcer on right leg redressed. Area on left appears healed.	Significant events	1021	
	Settled and slept well. C/O sore shoulders. Analgesia given (p1017).	Nursing care plan	1003-1017	
	Drug charts indicate: • Dihydrocodeine: Dr Barton prescribes PRN, dose unclear. Dates and times of administration unclear.	Drug charts	995	
23/2/96	Reviewed by Dr Barton. *Catheterised last night. 500ml residue.*	Clinical notes	975	

		Nursing care plan Significant events	1003-1017 1021	
24/2/96	Reviewed by Dr Barton. *Significant events (Joines): Pain not controlled properly by D.F.118. Seen by Dr Barton – for MST 10mg BD. Nocte: Comfortable night.*	Significant events	1021	
	Red and broken sacrum. Broken area sprayed (p1004). Comfortable (p1017).	Nursing care plan	1003-1017	
	Drug charts indicate: • MST: Dr Barton prescribes 10mg bd 06.00 and 18.00. Administered.	Drug charts	997	

25/2/96	Drug charts indicate: • MST: 10mg bd 06.00 and 18.00 administered.	Drug charts	997	
		Nursing care plan Significant events	1003-1017 1022	
26/2/96	Reviewed by Dr Barton. *Family seen and well aware of prognosis and treatment plan. Bottom very sore. Needs Pegasus mattress. Institute sc analgesia if necessary.*	Clinical notes	975	
	Seen by Dr Barton. MST→20mg BD. She will see Mrs Lavender @ 14.00 (Joines). *14.30: Son and wife seen by Dr Barton – prognosis discussed. Son is happy for us to just make Mrs Lavender comfortable and pain-free. Syringe driver explained (Joines).*	Significant events	1022	

	Drug charts indicate: • MST: 10mg administered at 06.00, then discontinued. 20mg bd commenced at 22.00. • Diamorphine: Code A prescribes 80-160mg/24hrs PRN by subcutaneous infusion. Not administered. • Midazolam: Code A prescribes 40-80mg/24hrs PRN by subcutaneous infusion. Not administered. • Hyoscine: Code A prescribes 400-800µg/24hrs PRN by subcutaneous infusion. Not administered.	Drug charts	995, 997	
27/2/96	Drug charts indicate: • MST: 20mg bd administered. Continued until 22.00 on 3/3/96.	Drug charts	997	
	Sacrum: No spray applied. Dressed. Area blackened and blistered (p1004). *Analgesia administered. Fairly effective. Able to help when dressing this am (p1013).*	Nursing care plan	1003-1017	

4/3/96	*Patient complaining of pain and having extra analgesia PRM. MST dose increased to 30mg BD by Dr Barton.*	Significant events	1022	
	S/B physio. Exercises – 3 turns of head to right and 5 neck retractions every 2 hours. Elsie needs reminding. Analgesia increased (p1013).	Nursing care plan	1003-1017	
	Drug charts indicate: • MST: Dr Barton increases dose to 30mg twice daily. Administered.	Drug charts	992	
5/3/96	Reviewed by Dr Barton. *Has deteriorated over last few days. In some pain therefore start sc analgesia. Let family know.*	Clinical notes	975	

	Patient's pain uncontrolled. Very poor night. Syringe driver commenced at 09.30. Son contacted by telephone, situation explained (Couchman).	Significant events	1022	
	Pain uncontrolled – patient distressed. Syringe driver commenced 09.30. Son informed.	Nursing care plan	1013	
	Drug charts indicate: • Diamorphine: Dr Barton prescribes 100-200mg/24hr by subcutaneous infusion. 100mg/24hrs administered. • Midazolam: Dr Barton prescribes 40-80mg/24hrs by subcutaneous infusion. 40mg/24hr administered. • Hyoscine: Dr Barton prescribes 400-800µg/24hrs PRN by subcutaneous infusion. Not administered.	Drug charts	990-991	

Code A	Reviewed by Code A. *Further deterioration. SC analgesia commenced. Comfortable and peaceful. Happy for nursing staff to confirm death.*	Clinical notes Nursing care plan	975 1003-1017	
	S/B Code A. Medication other than through syringe driver discontinued.	Significant events	1023	
	Pain well controlled. Syringe driver renewed at 9.45am.	Nursing care plan	1013	
	Drug charts indicate: • Diamorphine 100mg/24hr administered. • Midazolam: 40mg/24hr administered. • Medication other than by syringe driver stopped.	Drug charts	991	
	Death recorded at 9.28pm.	Clinical notes Significant events	975 1023	

	Cause of death: (I) CVA (II) Diabetes mellitus.	Death certificate		

GMC – v – DR JANE BARTON

CHRONOLOGY: PATIENT J – GEOFFREY PACKMAN

Date of Birth: 15/4/32

Date:	Event:	Source:	Page(s):	Comments:
30/6/99	Reviewed by Code A, consultant dermatologist, in relation to bilateral severe leg oedema. *Bilateral severe leg oedema with some leg ulceration secondary to venous hypertension. Would like to apply four layer bandaging.*	Correspondence	31	
		Correspondence Clinical notes	33 39	
6/8/99	Admitted to A&E, Queen Alexandra Hospital, following a fall at home. *Fall at home. Unable to mobilise. Obese. Diagnosis: Bilat LL oedema/ulcers on L, obsesity, not [unclear]. Admit to Anne Ward. No acute care needed in A&E.*	A&E notes	29, 43	

	Admitted to Anne Ward. ECG, chest x-ray and blood test performed. Swabs from groin and leg ulcers obtained. Intravenous antibiotics commenced. *Admission via A&E. PC: ↓ mobility. HPC: Obesity, bilaterial lower leg oedema, ↑ swelling legs over past 6/12, ulcers on legs for 1/12 L calf R calf, 1/12 ↑ weakness, now unable to mobilise. Cellulitis groin and L lower leg. Plan: Urinalysis, blood tests, chest x-ray, ECG, swabs from groin and ulcers, IV antibiotics, ↑ diuretics.*	Admission notes	44-46	
	Reviewed by Code A registrar. *Cellulitis L leg, chronic leg oedema, poor mobility, morbid obesity, ↑ BP, ?AF. Plan: As above, clexane as DVT prophylaxis, repeat ECG to confirm AF, if AF → anticoag. Needs CXR +/- echo ? LV dysfunction. If AF and LV good consider sotalol. Watch diuretics don't → dehydration.* *Dowse: In view of premorbid state + multiple medical problems, not for CPR in event of arrest.*	Clinical notes	47	

	Catheterised due to incontinence and broken skin around groin. All broken areas covered with bioclusive. Commenced on IV antibiotics. Temp up to 38.7°C at 20.10. 1g paracetamol given. Diet and fluids taken (p134).	Nursing notes	125, 134, 144, 150, 152	
		Patient profile Drug charts Analysis reports	106 176-182 207, 226-236	
7/8/99	Reviewed by Dr Grunstein and registrar. *Morbid obesity – says he was walking till about a week back, however has pressure sores on low back. Doesn't look that ill. Get good L/x from NOK. Continue IV antibiotic over w/e, mainly a nursing problem. Watch renal function once infection clears.*	Clinical notes	48	

	Buttocks continually oozing, bioclusive not staying in situ. Nocte: Geoff reports a good night, sleeping for big periods. Groin/[unclear] still leaking. Hoisted up bed this morning. Taking oral fluids well.	Nursing notes	135	
8/8/99	Reviewed on ward. *IV antibiotics. Spoke with wife. She is very stressed,* [redacted] *Discussed that* Code A *will probably need rehab/long term care (p125).* *Full assisted wash given, catheter draining, remains on bed rest (p135).* *Low grade pyrexia today, IV antibiotics continued (p144).* *Allevin renewed to sacrum. Groin and [unclear] crease much improved (p152-153).*	Nursing notes	125, 135, 144, 150, 152-153, 157	
9/8/99	Reviewed on ward. *Dr Reid: Cellulitis L leg settling. Oedema L → R foot – continue frusemide. Apyrexial.*	Clinical notes	49	

	Spoke with wife. Informed of what Dr Reid had said. Looking to go to GWMH (p124). *Remains on bed rest, dressing in sacral cleft renewed. Chatted with Geoff about losing weight. He would like to chat with dietician (p135-136).*	Nursing notes	124, 135-136	
10/8/99	Reviewed on ward. *Patient well, cellulitis improving on antibiotics, still awaiting physiotherapy.*	Clinical notes	49	
	S/B OT for initial interview. Will liaise with physio and ward staff re future plans (p124). *Nocte: Excellent night sleeping soundly for most of it on side (p136).* *Benzylpenicillin given. Apyrexial this afternoon (p144).* *Ability to mobilise remains unchanged (p151).* *Wounds appear improved (p153).*	Nursing notes	124, 136, 144, 151, 153	

11/8/99	Reviewed by registrar. *Patient well. Cellulitis improved on Ab. Continue physio. Apyrexial.*	Clinical notes	50	
	Request made for occupational therapy assessment.	Correspondence	107	
	Full wash given. Dressing changed. Stood with physio using neurological table and 5 members of staff (p136). Large necrotic blister observed on left heel (p137).	Nursing notes	124, 136-137, 145, 151, 153	
12/8/99	Reviewed by dietician. *Due to leg ulcers and pressure areas on lower back, inappropriate to give weight reducing [missing] (p124). Groin very offensive, appears very sore from sweating. Bioclusive applied to abdominal flap as very sore and red. Remains bright in mood (p137).*	Nursing notes	123, 124, 137, 153	

13/8/99	Reviewed by registrar. *Carry on antibiotics for total of 10 days. Continue oral fluids. Continue dressings as now. Transfer to Dryad Ward on 16/8/99.*	Clinical notes	51, 53	
	Full bed bath given. Groin area much better than yesterday. Dressings to sacrum intact. Bioclusive applied to left heel as blistered and soft (p137).	Nursing notes	122, 137-138	
15/8/99	Notes record Dryad Ward bed unavailable. *Assisted wash given. Serous fluid leakage continues. Appears comfortable at time of report. Uncomplaining afternoon. Nocte: Slept for long periods, turned from side to side with patient participation, slight leakage of serous fluid from sacral sores (p138-139).* *Remains in bed. Requires 4 nurses to roll for dressing changes (p151).* *All dressings changed. Slough +++ and necrotic areas observed. Malodorous + exuding from all areas of skin breakdown. Intrasite, allevyn + bioclusive to large broken areas and intrasite + bioclusive to smaller wounds (p156).*	Nursing notes	120, 138-139, 145, 151, 153, 156	

16/8/99	Reviewed. Dryad Ward bed unavailable. Seen by Dr Tandy. *Obese, cellulitis, p.sores – buttocks/sacrum, thighs. Legs – top much better. → Dryad when bed available.*	Clinical notes	52	
	Blister on L heel still evident. Dressing renewed with granuflex (p112). *Washed and changed with maximum assistance. Dressing renewed to heel (p139).*	Nursing notes	112, 120, 139, 145, 153	
18/8/99	Reviewed by registrar. *Wounds look better. Stop antibiotics from tomorrow. Continue as planned.*	Clinical notes	52	
	Reviewed by Dr Tandy, consultant geriatrician. *P sores – extensive. Feeds himself. Not mobilising. Black stool overnight – nil today. ° pain. Abdo [unclear]. Check Hb – R/O bleed.*	Clinical notes	53-54	

	Dressing renewed to heel. Dressings to bottom and groin intact. No complaints (p140). *Remains apyrexial (p145).* *Continuing to improve with physiotherapy. Continue to hoist until physios instruct nursing staff on appropriate transfers (p151).*	Nursing notes	112, 120, 140, 145, 151, 153	
20/8/99	Reviewed by registrar. *Nausea°, epigastric pain°. Epigastric tenderness° → stop felodipine. Check FBC (?↓Hb). For Gosport 23/8/99. Not for 555.*	Clinical notes	54	
	Heel reviewed and reassessed. Changed dressing to 15x20cm granuflex (p112). *Continue with current dressings. Review condition daily. Will write full step by step plan for Dryad Ward (p118).* *Following full reassessment of pressure sores, the wounds though malodorous don't appear to be as deep as first thought. Until necrotic tissue is removed, the wound appears to be a grade 3 (p128).* *All dressings changed. No complaints (p141).*	Nursing notes	112-119, 128, 141, 151	

23/8/99	Reviewed on ward. *Problems: Obesity, arthritis bilat knees, immobility, pressure sores. On high protein diet. MTS = very good. No pain. Better in himself. Legs: [Unclear], chronic skin change. Ulcers dressed yesterday. Need review later this week.*	Clinical notes	55	
	Admitted to Dryad Ward, GWMH. *PMH: Bilateral lower leg oedema, cellulitis, obesity, ↑ BP.*	Nursing notes	61-62	
	Hallman: Admitted from Anne Ward following episode of immobility and sacral sores. Catheterised. Able to feed himself.	Significant events	63	
		Nursing care plan	79-88, 97-101	

	Drug charts indicate: • Doxazosin, frusemide, clexane and paracetamol (1g four times daily) prescribed by doctor other than Dr Barton. Paracetamol 1g administered between 23/8/99 and 26/8/99.	Drug charts	173	
24/8/99	Blood sample sent for analysis (results on 25/8/99).	Analysis report	195	
	Drug charts indicate: • Temazepam: Dr Barton prescribes 10-20mg PRN. 10mg administered at 22.10.	Drug charts	171	
25/8/99	Verbal message from Dr Beasley to withhold clexane dose and review with Dr Barton mane. *Passing fresh blood PR. ? clexane. Verbal message from Dr Beasley to withhold 18.00. Dose and review with Dr Barton mane. Also vomiting. Metoclopramide 10mg given I.M. at 17.55 with good effect.*	Significant events	63	

	Transferred to heavy duty bed. Patient slide and 6 members of staff used.	Contact record	69	
	Drug charts indicate: • Temazepam: 20mg administered at 22.05. • Gaviscon: 10ml administered at 12.00. Prescribed PRN by doctor other than Dr Barton, date unclear. • Metoclopramide: 10mg im 8 hourly prescribed verbally by Dr Beasley. 10mg administered at 17.55.	Drug charts	171, 174	

26/8/99	Dr Ravi consulted re clexane. Reviewed by Dr Barton. *Hamblin: Fairly good morning. No further vomiting. Dr Ravi contacted re clexane. Advised to discontinue. Repeat Hb today and tomorrow. Not for resuscitation. Unwell at lunchtime. Seen by Dr Barton this afternoon – await results of Hb. Further deterioration – c/o ? indigestion, pain in throat not radiating – vomited again this evening. Verbal order from Dr Barton diamorphine 10mg stat – given at 18.00. Metoclopramide 10mg given IM. Mrs Packman will visit this evening.* *Hallman: 1900: Dr Barton here. For oramorph 4 hourly. Wife seen by Dr Barton, explained Mr Packman's condition and medication used.*	Significant events	63	
	Hb: 7.7. Many attempts made to phone these results, no answer from GWMH switchboard.	Analysis report	210	
	Visited to ensure no problems with moving and handling. Discussed situation with sister. Agreed to encourage Mr Packman to do as much as he can himself. Physio to see pt today with view to starting pressure physio.	Contact record	69	

	Review by Dr Barton. *Called to see male, clammy, unwell. Suggest ? MI treat stat diamorph and oramorph overnight. Alternative possibility GI bleed but no haematemisis. Not well enough to transfer to acute unit. Keep comfortable. Happy for nursing staff to confirm death.*	Clinical notes	56	
	Drug charts indicate: • Metoclopramide: 10mg administered at 17.40. • Diamorphine: 10mg im administered at 18.00. Prescribed verbally. Subsequent prescription by Dr Barton, date unclear. • Oramorph: Dr Barton prescribes 5ml (10mg) four hourly. Not administered. • Oramorph: Dr Barton prescribes 5-10ml (10-20mg) qds and 10ml (20mg) nocte. 10ml (20mg) nocte administered.	Drug charts	171, 174-175	

27/8/99	Reviewed by Dr Barton. *Hamblin: Some marked improvement since yesterday. Seen by Dr Barton this am – to continue with oramorph 4 hourly – same given, tolerated well. Some discomfort this afternoon, especially when dressings being done. Wife has visited this afternoon and is aware that condition could deteriorate again. Still remains poorly.*	Significant events	64	
	Drug charts indicate: • Oramorph: Four doses administered (dose unclear) during day. 10ml (20mg) nocte administered.	Drug charts	175	
28/8/99	Reviewed by Dr Barton. *Remains poorly but comfortable. Please continue opiates over weekend.*	Clinical notes	56	

	Hallman: Remains very poorly – no appetite, has refused all food. Code A *visited – very distressed* Sensitive personal data Sensitive personal data *Nocte (28th-29th): Oramorph given as prescribed. Condition remains poorly and variable. Dressings remain intact.*	Significant events	64	
	Drug charts indicate: • Oramorph: Four doses administered (dose unclear) during day. 10ml (20mg) nocte administered.	Drug charts	175	
29/8/99	Drug charts indicate: • Oramorph: Four doses administered (dose unclear) during day. 10ml (20mg) nocte administered.	Drug charts	175	
	Nocte (29th-30th): Slept for long periods. Oramorph given as prescribed.	Significant events	64	

30/8/99	*Hamblin: This mane 30/9/99 c/o left abdominal pain. Condition remains poor. Syringe driver commenced at 14.45. No further complaints of abdominal pain. Very small amount diet taken, mainly puddings. Recatheterised. When possible encourage fluids. Dressings renewed.*	Significant events	64	
	Drug charts indicate: • Oramorph: Two doses administered (dose unclear) during day. • Diamorphine: 40mg/24hrs administered at 14.45, pursuant to undated prescription by Dr Barton for 40-200mg/24hrs by subcutaneous infusion. • Midazolam: 20mg/24hrs administered at 14.45, pursuant to undated prescription by Dr Barton for 20-80mg/24hrs by subcutaneous infusion.	Drug charts	174-175	
31/8/99	*Appeared to have comfortable and peaceful night (30th-31st). This morning has passed a large amount of black faeces.* *Nocte: Comfortable night – continues to pass tarry black faeces.*	Significant events	64	

	Drug charts indicate: • Diamorphine: 40mg/24hrs administered at 15.45. • Midazolam: 20mg/24hrs administered at 15.40.	Drug charts	174	
1/9/99	Reviewed by Dr Reid. *Rather drowsy, but comfortable. Passing [unclear] stools. Abd huge, but quite soft. Pressure sores over buttock and across posterior aspect of R/L thigh. Remains confused. For TLC. Wife aware of poor prognosis.*	Clinical notes	56	
	Hamblin: Syringe driver renewed at 19.15 with diamorphine 60mg + midazolam 60mg as previous dose not controlling symptoms. Dressings renewed this afternoon. Mrs Packman has visited and is aware of poor prognosis. *Nocte: Incontinent of black tarry faeces. Peaceful night. All care given.*	Significant events	65	

	Drug charts indicate: • Diamorphine: 40mg/24hrs administered at 15.45. Increased to 60mg/24hrs at 19.15. • Midazolam: 40mg/24hrs administered at 15.45. Increased to 60mg/24hrs at 19.15.	Drug charts	174	
2/9/99	Drug charts indicate: • Diamorphine: 90mg/24hrs administered at 15.40. • Midazolam: 80mg/24hrs administered at 15.40. • Hyoscine: Dr Barton prescribes 800-2000µg/24hrs by subcutaneous infusion. Not administered.	Drug charts	174-175	
	Diamorphine increased to 90mg/24hrs. Midazolam 80mg.	Significant events	65	
Code A	Death recorded at 13.50.	Clinical notes Significant events	56 65	

GMC – v – DR JANE BARTON

CHRONOLOGY: PATIENT C – EVA PAGE

Date of Birth: 29/12/09

Date:	Event:	Source:	Page(s):	Comments:
30/4/97	Admitted to Queen Alexandra Hospital, following a collapse. Diagnosed with a reversible ischaemic neurological deficit. Commenced on aspirin. Discharged back to residential home on 7/5/97.	Correspondence Discharge summary Nursing notes Clinical notes	52-57 58 136-139 160-165	
6/2/98	Admitted to Queen Alexandra Hospital, Department of Medicine for Elderly People. Diagnosis includes probable carcinoma of the bronchus and depression. *GP referral. In residential home. General deterioration, c/o nausea, ↓ appetite, now dehydrated. Feels "depressed" last few weeks. GP prescribed sertraline.* *Past medical history: AF, CCF.* *Chest clear. No ankle oedema.* *Patient willing to accept ↑ oral fluids.*	Clinical notes	296	

		Spell summary Patient profile Care plan Nursing notes X-ray report	202 207 228 232 290	
19/2/98	Transferred to Charles Ward, Queen Alexandra Hospital, under Dr Lord. *Referral to Charles Ward. CA bronchus probably (no histology). Diagnosis based on CXR. Admitted 6/2/98, general deterioration. Exam: Sleepy but responsive, answers appropriate, states he is frightened but doesn't know why, says she has forgotten things. Chest clear. Abdomen soft. Legs ° oedema ° pressure sores. Patient feels in general tired and very thirsty.* *Plan: Encourage oral fluids, s/c fluid overnight if tolerated. Continue antidepressant.*	Clinical notes	302	
	Ate soup and puddings for supper. Fluids encouraged. Needing a lot of reassurance. Appears reluctant to go to sleep. s/c midazolam 2.5mg given @ 18.50 with effect.	Nursing notes	235	

		Transfer form Spell summary Care plan	196 198 218-230	
25/2/98	Reviewed by Dr Lord. *Confused and some agitation. Says she's frightened. Not sure why. Tends to scream at night. Not in pain. Try thioridazine. Transfer to GWMH.*	Clinical notes	304	
27/2/98	Transferred to Dryad Ward, GWMH. *Diagnosis: Ca bronchus, anorexia, depression, dehydration, falls. Diet: Normal as tolerated. Requires assistance with ADLs. Drugs administered: Thioridizine, paracetamol PRN. Remains withdrawn and anxious at times. Calls for assistance frequently. Indwelling catheter for retention. Requires total assistance with hygiene needs. Using Pegasus mattress. Red sacrum. Transfers with 2 nurses at the moment.*	Transfer form	196-197	

	Reviewed by Dr Barton. *Transfer to Dryad Ward continuing care. Generally unwell, off legs, not eating. Catheterised. Needs help with eating and drinking. Needs hoisting. Barthel 0. Family seen and well aware of prognosis. Opiates commenced. Happy for nursing staff to confirm death.*	Clinical notes	304	
	Admitted today from Charles Ward for palliative care. An anxious lady who calls out frequently and needs reassurance. Normal diet and fluids. Incontinent of faeces. Needs total help with hygiene needs. Able to hold a beaker and pick up small amounts of food, but needs a lot of encouragement. *Night: Settled for short time only. Calling out quite frequently. Drinking well.*	Significant events	170	
		General information Nursing care plan Spell summary	166, 169 174-192 194	

	Drug charts indicate: • Oramorph: Dr Barton prescribes 2.5ml (5mg) PRN. • Thioridazine: Dr Barton prescribes 25mg PRN. • Dr Barton also prescribes digoxin, frusemide, ramipril, sotalol, sertraline and lactulose.	Drug charts	272	
28/2/98	*Very distressed, calling for help and saying she is afraid. Thioridazine given with no relief. Patient remains distressed. Oramorph 2.5mg given with no relief. Doctor notified. S/B doctor for regular thioridazine and heminevrin nocte.*	Significant events	170	
	Can make her wishes known quite well. Does as she is asked. Pain: Yes on movement. Pegasus mattress. Urinary catheter (p178). *Independent turning in bed. Two members of staff for bath/shower, with hoist (p179).* *Encourage fluid intake (p184).* *Needs help with personal hygiene but should be encouraged to do for herself what she can (p186).*	Nursing care plan	174-192	

	Drug charts indicate: • Oramorph: 5mg administered at 16.20. • Thioridazine: 25mg administered at 13.00. Further unclear dose then prescribed. • Heminevrin: Unclear dose prescribed. Administered at 22.00.	Drug charts	272, 274, 276	
1/3/98	Drug charts indicate: • Thioridizine: Two doses administered. • Heminevrin: One dose administered, then discontinued.	Drug charts	276	
	Slept well but calling. Shouting from approx 05.30. Spat out all medication.	Nursing care plan	181	
2/3/98	Seen by Code A *No improvement on major tranquilliser. I suggest adequate opiates to control fear and pain. Son to be seen by* Code A *today.*	Clinical notes	305	

	Reviewed by Dr Lord. *Spitting out thioridazine. Quieter on prn SC diamorphine. Fentanyl patch started today. Agitated and calling out even when staff present. Diagnosis (1) Ca bronchus, (2) ? cerebral metastases. Continue fentanyl patches.* *Later: Son seen. Concerned about deterioration today. Explained about agitation and that drowsiness probably due in part to diamorphine. Accepts his mother is dying. Agrees to continue present plan of medication.*	Clinical notes	305	
	Commenced fentanyl 25µg this am. Very distressed this morning. Seen by Dr Barton. To have diamorphine 5mg i/m. Given at 08.10. *S/B Dr Lord. Diamorphine 5mg I/M given.* *For syringe driver s/c diamorphine boarded.*	Significant events	170	

	Drug charts/nursing notes indicate: • Fentanyl: Dr Barton prescribes Fentanyl 25 patch x 5 days PRN. Patch administered at 08.00. • Diamorphine: Dr Barton prescribes 5mg. Administered at 08.00 and 15.00. • Thioridizine: One dose administered, then discontinued.	Drug charts	272, 276	
Undated	Drug charts indicate: • Diamorphine: Dr Barton prescribes 20-200mg/24hrs (in daily review prescriptions, marked "PRN") by subcutaneous infusion. • Midazolam: Dr Barton prescribes 20-80mg/24hrs (in daily review prescriptions, marked "PRN") by subcutaneous infusion. • Hyoscine: Dr Barton prescribes 200-800µg/24hrs (in daily review prescriptions, marked "PRN") by subcutaneous infusion.	Drug charts	278	
3/3/98	Drug charts indicate: • Diamorphine: 20mg/24hrs administered from 10.50. • Midazolam: 20mg/24hrs administered from 10.50.	Drug charts	278	

	Death recorded at 21.30.	Significant events Nursing care plan Clinical notes	171 181 306	

GMC – v – Code A

CHRONOLOGY: PATIENT A – LESLIE PITTOCK

Date of Birth: Code A

Date:	Event:	Source:	Page(s):	Comments:
27/4/92	Reviewed at Knowle Hospital, primarily in respect of depression. Treatment continues through 1992 and into 1993.	Clinical notes Correspondence	8-35 76	
	27/4/92: Admitted for respite cover by Code A *Increased agitated depression. Deterioration in mental state over the last two months. Decreased appetite.*	Clinical notes	9	
29/1/93	Reviewed at Hazledene Rest Home following discharge from Knowle Hospital. *Coping well. Anxious. Feels safe. No suicidal thoughts.*	Clinical notes	36	

21/6/93	Admitted to Knowle Hospital for depression. Discharged on 9/7/93.	Clinical notes Correspondence	37-39 78	
	Admission to Alverstoke Ward. Increased chronic resistant depression. Feeling v low. Sleep v poor. Good appetite. Constipation a problem for a long time.	Clinical notes	37	
1/9/95	Reviewed at Hazledene Rest Home due to reported change in condition. *Manager of rest home reports change in condition. Loss of 1st 2lbs in two months. Physically frailer, anxious, falling at times. To be admitted to Mulberry Ward for reassessment of drug regime and provision of interim intensive support.*	Clinical notes	45-46	

14/9/95	Admitted to GWMH under Code A consultant psychiatrist, suffering from depression. Reviewed by registrar, Code A . *Chronically depressed. Patient feels main problem is constipation. Constant anxiety. Appetite poor. Embarrassed about feeding in public. Flat effect on mental state examination. Cognitive function 8/10. Low mood, not agitated. Very immobile, shuffling gait. Pale. No oedema. Chest clear. Soft abdomen. Mood and self-image deteriorating. Plan to continue medication, encourage diet.*	Clinical notes	48-52	
	Care plan: Goal: To help elevate mood to a level where he is able to return to his rest home.	Care plan	169	
	Specific events: Admitted at request of Code A *. Recently more depressed. Less able to care for self – requiring assistance with washing, dressing etc.*	Specific event notes	181	

		Drug charts Admission notes	96 158	
18/10/95	Reviewed by Code A *Eating well. Seems better and brighter. Receiving visitors. For discharge next week.*	Clinical notes	55	
		Ward round notes Nursing notes Specific event notes	168 175 182	
24/10/95	Discharged to Hazledene Rest Home. *Discharge letter: Admitted complaining of exacerbation of chronically depressed mood. Physical examination: Mobility was very poor, but otherwise little abnormality. Medications were continued. Food intake very good. Mood improved.*	Correspondence	57-59	

13/12/95	Admitted to Mulberry Ward, GWMH, under Code A *Complains "everything's horrible." Verbally aggressive. Staying in bed. Not eating well. Withdrawn. No hallucinations or delusions. Monosyllabic. Shuffling gait. Two to mobilise.*	Clinical notes	63-64	
	Admission notes: The rest home cannot cope with him. He has put himself to bed and refuses to get up. Physically and verbally aggressive. Lack of energy and self-motivation.	Admission notes	126	
		Care plan Nursing notes	143 145	
22/12/95	Prescribed erythromycin (antibiotic) for chest infection. *Diarrhoea this morning. Generally weak. Left basal crepitations. Chest infection. Encourage oral fluids.*	Clinical notes	65	

	Has been drowsy. Commenced on erythromycin. Nursed in bed. Remains physically unwell. Sleeps most of afternoon.	Specific event notes	149	
27/12/95	Reviewed by Code A Prescribed cephalosporin (antibiotic). Chest x-ray and abdominal x-ray conducted. *Chesty, poorly, abusive, not himself at all. Reassess mood once physically better. Possible further investigation of bowels. Catheterised last week due to urine retention. Geriatrician review may be helpful.*	Clinical notes	66	
		Ward round notes Care plan Nursing notes Specific event notes	136 139 141-147 150	

2/1/96	Referred by Code A to Dr Lord, consultant geriatrician. *On this admission, mobility deteriorated dramatically and developed chest infection. Chest now clearing. Remains bed-bound. May well be secondary to depression. Grateful for suggestions for improving physical health.*	Clinical notes	67	
		Radiological report Specific event notes	117 151	
3/1/96	Reviewed by Code A *Poor food intake. Fluids OK. Deteriorating. Some breaks in skin now. To start fortisips and high protein diet. Needs more time to convalesce. Probably will need NH.*	Clinical notes Nursing notes Specific event notes	67 142 151	
	Les has been out of bed for couple of hours, but back into bed. Not eating and drinking very well.	Nursing notes	142	

	8.10pm: Seems a little brighter today. Up in his chair for short while this morning. Not eating but drinking really super, supplemented with fortisip.	Significant events	151	
		Drug charts Ward round notes	82 137	
4/1/96	Reviewed by Dr Lord. *Chronic resistant depression. Very withdrawn. Completely dependent – Barthel 0. Superficial ulceration of left buttock and hip. Hypoproteinaemia. Suggests high-protein drinks, bladder wash-outs. Happy to take him to GWMH. RH place can be given up as unlikely to return there.*	Clinical notes	68	
	All nursing care given.	Nursing notes	142	

	Lord: Has recovered from recent chest infection, but is completely dependent with Barthel of 0. Eating very little, but will drink moderate amounts with encouragement. Overall, prognosis poor. Happy to arrange transfer to Dryad Ward, GWMH.	Correspondence	188	
		Specific event notes	152	
5/1/96	Admitted to Dryad Ward, GWMH. Reviewed by Dr Barton. *Transfer from Mulberry. Immobility. Depression. Broken sacrum. Small superficial areas on right buttock. Both heels suspect. Catheterised. Transfers with hoist. Longstanding depressive on lithium and sertraline.*	Clinical notes	196	
	Drugs patient was receiving prior to transfer prescribed – sertraline, lithium, diazepam, thyroxine.	Drug charts	199	

		Specific event notes Transfer details	152 195	
10/1/96	Reviewed by Dr Tandy. *Depression. Catheterised. Superficial ulcers. Barthel 0. Will eat and drink. For TLC.*	Clinical notes	196	
	Drug charts indicate: • Oramorph: Dr Barton prescribes 2.5ml (5mg) to be given five times daily. 5mg administered at 22.00.	Drug charts	200	
		Nursing care plan	218	

Undated	Drug charts indicate: • Diamorphine: Dr Barton prescribes 40-80mg/24hrs by subcutaneous infusion. • Hyoscine: Dr Barton prescribes 200-400µ/24hrs by subcutaneous infusion. • Midazolam: Dr Barton prescribes 20-40mg/24hrs by subcutaneous infusion.	Drug charts	200	
11/1/96	Drug charts indicate: • Oramorph: 5mg administered at 06.00. Dr Barton then prescribes 2.5ml (5mg) four times daily plus 5ml (10mg) nocte. 5mg administered at 10.00, 14.00 and 18.00. 10mg administered at 20.00. This dose regimen continues until 06.00 on 15/1/96. • Diamorphine: Dr Barton prescribes 80-120mg/24hrs PRN by subcutaneous infusion. • Hyoscine: Dr Barton prescribes 200-400µg/24hrs PRN by subcutaneous infusion. • Midazolam: Dr Barton prescribes 40-80mg/24hrs PRN by subcutaneous infusion.	Drug charts	200-202	

15/1/96	Drug charts indicate: • Diamorphine: 80mg/24hrs administered. • Hyoscine: 400µg/24hrs administered. • Midazolam: 60mg/24hrs administered.	Drug charts	201	
		Nursing care plan	218-228	
16/1/96	Drug charts indicate: • Diamorphine: 80mg/24hrs administered. • Hyoscine: 400µg/24hrs administered. • Midazolam: 60mg/24hrs administered. • Haloperidol: 5-10mg/24hrs prescribed. 5mg/24hrs administered.	Drug charts	201-203	
		Nursing care plan	218-228	

17/1/96	Drug charts/nursing notes indicate: • Diamorphine: 80mg/24hrs administered. Dosage then increased by Dr Barton to 120mg/24hrs (dated 18/1/96 but administered from 17/1/96). 120mg/24hrs administered. • Hyoscine: 400µg/24hrs administered. Dosage then increased by Dr Barton to 600µg/24hrs (dated 18/1/96 but administered from 17/1/96). 600µg/24hrs administered. Dosage then increased by Dr Barton to 1200µg/24hrs (dated 18/1/96 but administered from 17/1/96). 1200µg/24hrs administered. • Midazolam: 60mg/24hrs administered. Dosage then increased by Dr Barton to 80mg/24hrs (dated 18/1/96 but administered from 17/1/96). 80mg/24hrs administered. • Haloperidol: 10mg/24hrs administered. Dosage then increased by Dr Barton to 20mg/24hrs. 20mg/24hrs administered.	Drug charts	190, 201-203	
		Nursing care plan	218-228	

	09.00: S/B Dr Barton. Medication increased at 08.25 as patient remains tense and agitated. Chest very bubbly. Distressed in turning. *14.30: S/B Dr Barton. Medication reviewed and altered. Syringe driver renewed at 15.35 (two drivers).* *20.30: Further deterioration. Appears more settled, although still aware of when being attended to.*	Nursing notes	210	
18/1/96	Reviewed by Dr Barton. *Further deterioration. SC analgesia continues. Difficulty controlling symptoms. Try nozinan.*	Clinical notes	198	
	Poorly condition continues to deteriorate. *15.00: Syringe driver recharged with diamorphine 120mg, midazolam 80mg, hyoscine 1200µg, haloperidol 20mg and nozinan 50mg. Appears comfortable in between attentions.*	Nursing notes	210	
		Nursing care plan	218-228	

	Drug charts/nursing notes indicate: • Diamorphine: Dr Barton prescribes 120mg/24hrs by subcutaneous infusion (actually commencing on 17/1/96). 120mg/24hrs administered. • Hyoscine: Dr Barton prescribes 600µg/24hrs, then 1200µg/24hrs, by subcutaneous infusion (both actually commencing on 17/1/96). 1200µg/24hrs administered on 18/1/96. • Midazolam: Dr Barton prescribes 80mg/24hrs by subcutaneous infusion. 80mg/24hrs administered. • Haloperidol: Dr Barton prescribes 20mg/24hrs by subcutaneous infusion. 20mg/24hrs administered. • Nozinan: Dr Barton prescribes 50mg/24hrs PRN. 50mg/24hrs administered.	Drug charts	189-190, 203	
19/1/96	Drug charts/nursing notes indicate: • Diamorphine: 120mg/24hrs administered. • Hyoscine: 1200µg/24hrs administered. • Midazolam: 80mg/24hrs administered. • Haloperidol: 20mg/24hrs administered. • Nozinan: 50mg/24hrs administered.	Drug charts	189	

	Marked deterioration in already poorly condition. All nursing care continued. Breathing very intermittent. Colour poor. *15.00: Syringe driver recharged.*	Nursing notes	211	
		Nursing care plan	218-228	
20/1/96	Drug charts/nursing notes indicate: • Diamorphine: 120mg/24hrs administered. • Hyoscine: 1200µg/24hrs administered. • Midazolam: 80mg/24hrs administered. • Haloperidol: Discontinued. • Nozinan: Dosage increased to 100mg/24hrs. 100mg/24hrs administered.	Drug charts	189	
	Has been unsettled on haloperidol in syringe driver. Verbal order to increase nozinan 50mg to 100mg.	Clinical notes	198	

	Verbal order from Dr Brigg to double nozinan and quit haloperidol. Syringe driver recharged at 18.00. Appears comfortable.	Nursing notes	211	
		Nursing care plan	218-228	
21/1/96	Drug charts/nursing notes indicate: • Diamorphine: 120mg/24hrs administered. • Hyoscine: 1200µg/24hrs administered. • Midazolam: 80mg/24hrs administered. • Nozinan: 100mg/24hrs administered.	Drug charts	189	
	Much more settled. Quiet breathing. Rate 6/min. Not distressed. Continue. (Briggs).	Clinical notes	198	

	Very settled today. All care given. *18.15: Condition unchanged. Driver recharged at 17.45. Appears comfortable.* *Breathing quietly and slowly.*	Nursing notes	211-212, 228	
22/1/96	Drug charts/nursing notes indicate: • Diamorphine: 120mg/24hrs administered. • Hyoscine: 1200µg/24hrs administered. • Midazolam: 80mg/24hrs administered. • Nozinan: 100mg/24hrs administered.	Drug charts	189	
	Poorly but very peaceful. Driver recharged.	Nursing notes	212	
		Nursing care plan	219, 228	

23/1/96	Drug charts/nursing notes indicate: • Diamorphine: 120mg/24hrs administered. • Hyoscine: 1200µg/24hrs administered. • Midazolam: 80mg/24hrs administered. • Nozinan: 100mg/24hrs administered.	Drug charts	189	
	Poorly condition remains unchanged. Remains peaceful. *15.45: Driver recharged.*	Nursing notes	212	
		Nursing care plan	225	
24/1/96	Death recorded at 1.45am.	Clinical notes Nursing notes	198 212	
	Cause of death: Bronchopneumonia.	Death certificate		

GMC – v – DR JANE BARTON

CHRONOLOGY: PATIENT I – ENID SPURGIN

Date of Birth: Code A

Date:	Event:	Source:	Page(s):	Comments:
19/3/99	Admitted to Royal Haslar Hospital, following a fall, causing right sub-trochanteric femur fracture. *PC: R femur sub-trochanteric fracture. Pulled over by dog and landed on R hip. PMH: Diabetes, MI, hypertension, epilepsy, CVA/TIA, [unclear]. Lives alone, self-caring, independent. O/E: Well alert + orientated, abraded R forearm/elbow. Plan: Admit F6, IV fluids pre-op, analgesia.*	Clinical notes	356	
	Takes no drugs and has no other health problems. Non-smoker. Has a brandy and ginger every morning at 11am. No difficulties breathing. Small appetite. Loves to walk her dog and do the garden. Sleeps a lot, always falling asleep on her chair. Patient is alert and understands everything although a little deaf.	Nursing assessment	70, 73, 76	

		Nursing notes Ambulance notes A&E notes	317 360 361	
	Drug charts indicate: • Diclofenac: 50mg administered, • Paracetamol: 1g administered.	Drug charts	328	
20/3/99	Anaesthetic pre-operative assessment at 12.00. *92 year old lady for DHS hip. Previously well – nil major medical problems. Analgesia: Volterol 50mg given + paracetamol 1g, nil else. Plan: Cyclizine 50mg + morphine 2mg iv, stop voltarol.*	Clinical notes	358-359	
	Reviewed by SHO following hallucinations. *Morphine 2mg → pt hallucination therefore nil further opiates. For spinal A @14.30.*	Clinical notes	359	

	Surgery carried out under spinal anaesthetic, with insertion of right dynamic hip screw. Blood transfusion given.	Operation record	363-370	
	Post-op review SHO: R leg held in external [unclear]. +++ ooze from wound, drainage approx 40mls – thigh subjectively 2 x size of left. ? haematoma. P = 88 reg. BP = 140/90. Pt c/o discomfort in leg and pain on palpation. Otherwise nil else.	Clinical notes	359	
	Nausea and pain controlled as per drug chart.	Nursing notes	315, 317	
	Drug charts indicate: • Paracetamol: 1g administered • Morphine: 2mg administered IV, then 5mg administered twice.	Drug charts	326, 328	

21/3/99	*AM: Seen by doctors today. X-ray checked and ok. Mrs Spurgin able now to get into chair. Please give morphine before moving Mrs Spurgin – a lot of pain on movement. Push fluids as much as possible.* *Nocte: Urine output poor. Bladder wash-out performed. IV fluids speeded up. Urine output improved. Recatheterised.*	Nursing notes	317	
	Reviewed by Dr Woods. *23.30: Urine output abysmal but pt not c/o thirst. Oral intake this AM ½ litre + IVI, but UO plummeted, then ↑ to 120mls in a single episode. Nurses asked to flush catheter – no obstruction. Clinically this lady is slightly dry but not excessively so, but when UO taken into account she is in acute pre-renal failure. Urgent U+Es requested. Ct blood, ct fluids are prescribed.* *Note: R hip painful +++ no ooze but thigh enlarged. Possible bleed into thigh but no evidence of hypovolaemia. Monitor.*	Clinical notes	371-372	
	Drug charts indicate: • Paracetamol: 1g administered. • Morphine: 5mg administered.	Drug charts	328	

22/3/99	Reviewed on ward round. *Poor oral fluid intake. Apyrexial. Needs check Hb today. Hb 11.1.*	Clinical notes	372	
	Sat out by physios. Drinking and eating much better today. Oral fluids pushed. *19.50: Oral intake of fluids encouraged. Urine output monitored. 1 hourly measurements satisfactory. Dressing changed due to large amount of ooze.*	Nursing notes	317-318	
	Drug charts indicate: • Paracetamol: 1g administered.	Drug charts	328	

23/3/99	*05.00: Patient removed catheter @ 05.00. In no obvious discomfort. Not reinserted.* *AM: No re-catheterisation. Moved patient to chair with 2 assistances. Patient has difficulty and pain ++ with mobility. Is able to wash face and upper torso on her own, needs assistance with lower torso. Redressed ulcer on R leg. Applied mepore dressing to small laceration to R ankle. Patient seems comfortable in chair.* *19.53: Transferral and mobilising not well. No ooze on wound on hip.*	Nursing notes	315	
	Drug charts indicate: • Paracetamol: 1g administered.	Drug charts	328	
24/3/99	Reviewed on ward round. *Skin v thin + fragile lower legs. Need to elevate. Would benefit from Dr Lord for rehab.*	Clinical notes	373	

	Referred to Dr Lord. *92 year old lady sustained sub-trochanteric fracture of R femur, having been pulled over by her dog. Previously well, with no significant past medical history, living alone and independently with no social service input. Transfused with 3 units of blood, but otherwise made unremarkable post-op recovery. Has proved quite difficult to get mobilised and her post-op rehabilitation may prove somewhat difficult. Quality of skin, especially lower legs, is poor and at great risk of breaking down. Would appreciate advice regarding her rehabilitation and consideration of a place at GWMH.*	Clinical notes	373-374	
	Reviewed by Dr Reid. *Fully orientated and able to give good account of herself. Main problem was pain in right hip and swelling of right thigh. Even a limited range of passive movement in right hip still very painful. Would like to be reassured that all well from orthopaedic viewpoint. If all is well, happy for transfer to GWMH for further assessment and hopefull remobilisation.*	Correspondence	301	

	Dr Reid: Still in a lot of pain, which is main barrier to mobilisation at present – could her analgesia be reviewed?	Clinical notes	374	
	Legs remain elevated. No episodes of incontinence. Dressings changed. *PM: Sat in chair this afternoon. Seen by Dr Reid.*	Nursing notes	315	
	Drug charts indicate: • Paracetamol: 1g administered.	Drug charts	328	
25/3/99	*WR: R leg ↑ swelling. Skin tissue-paper thin + very fragile. Haematoma developed + broken down. Dress with gelonet. Elevate. Ready for GWMH when bed available. Needs great care of skin + warn GWMH of skin state.*	Clinical notes	375	

	Mobilised to commode with 2 staff. Assisted with hygiene. No incontinence. Skin tear to back of R calf dressed with steri-strips jellonet-zyofoam with wool and crepe bandage. Mepore applied to R ankle. Very reluctant to mobilise. Needs encouragement.	Nursing notes	315, 318	
	Drug charts indicate: • Paracetamol: 1g administered.	Drug charts	328	
26/3/99	Transferred to Dryad Ward, GWMH. *She is now mobile from bed to chair with 2 nurses and can walk short distances with a zimmer frame. No urinary catheter. Sometimes incontinent at night. Skin on lower legs paper thin. Right lower leg very swollen and has a small break on the posterior aspect. Needs encouragement eating and drinking but can manage independently. Her only medication is analgesia (paracetamol) PRN.*	Transfer letter	23	

	Reviewed by Dr Barton. *Transfer to Dryad Ward. HPC: Fractured NO femur R 19-3-99. PMH: Nil of significance. No weight bearing. Tissue paper skin. Not continent. Plan sort out analgesia.*	Clinical notes	27	
	Admission for rehabilitation and gentle mobilisation. In Haslar she was mobile with zimmer frame and 2 nurses – short distances and apparently transferring satisfactorily. However, transfer has been difficult here since admission. Complained of a lot of pain for which she is receiving oramorph regularly now, with effect. Has very dry, tissue paper skin to lower legs, with small break on back of right calf. Legs are swollen. Eats and drinks with encouragement. Can feed herself. *Turnbull: Night: Requires much assistance with mobility at moment due to pain/discomfort. Oramorph 10mg given 23.15 + 5mg at 06.50.*	Significant events	132	

	Oramorph given for pain in hip (p89, 91). *Experiencing a lot of pain on movement (p96).* *Has wound on right elbow and right calf. Skin very fragile, right leg swollen and oedematous. Both wounds dressed (p104).* *Waterlow score 32 (p110).*	Nursing care plan	89, 91, 96, 104 110	
	Drug charts indicate: • Oramorph: Dr Barton prescribes 2.5-5ml (5-10mg) PRN subcutaneously. Dr Barton also prescribes as regular prescription 2.5ml (5mg) four times daily and 5ml (10mg) nocte. Three doses of 2.5ml (5mg) administered. One dose of 5ml (10mg) administered.	Drug charts	160, 164	

27/3/99	Drug charts indicate: • Oramorph: One dose of 2.5ml (5mg) administered then discontinued. Dr Barton then prescribes 5ml (10mg) four times daily and 10ml (20mg) nocte. Two 5ml (10mg) doses administered. One 10ml (20mg) dose administered. • Codydramol: Dr Barton prescribes two tablets four times daily.	Drug charts	164	
	Is having regular oramorph, but still in pain (p96). *Used commode, passed urine. In some pain, needs 2 nurses to transfer at present (p144).*	Nursing care plan	96, 144	
28/3/99	Drug charts indicate: • Oramorph: Two 5ml (10mg) doses administered, then discontinued. • Codydramol: Two tablets four times daily administered.	Drug charts	164	

	Has been vomiting with oramorph. Advised by Dr Barton to stop oramorph. Is now having metaclopramide TDS and codydramol. Vomited this afternoon after using commode. Refused supper.	Nursing care plan	96, 98	
Unclear	Drug charts indicate: • Metoclopramide: Dr Barton prescribes 10mg tds (pp Dr Barton, then counter-signed). Administered from 28/3/99 until 11/4/99.	Drug charts	178	
29/3/99	Drug charts indicate: • Codydramol: Two tablets four times daily administered.	Drug charts	164	
	Please review pain relief this morning (p98). *Both wounds redressed with paramed. Steri-strips removed from calf wound as were hanging off (p106).* *Barthel 6 (p113).*	Nursing care plan	98, 106, 113	

30/3/99	Drug charts indicate: • Codydramol: Two tablets four times daily administered.	Drug charts	164	
	Both wounds redressed with paranet. Steri-strips from surgery removed. One small area near top oozing slightly – mepore dressing in situ. Check in a couple of days (p106). *Henning: Sat out in chair for assisted wash/dressed. Zinc and castor oil applied to bottom, liquid paraffin 50/50 applied to legs (p150).*	Nursing care plan	106, 150	
31/3/99	Drug charts indicate: • Oramorph: 2.5ml (5mg) administered at 13.20. • Codydramol: Two tablets four times daily administered. • MST: Dr Barton prescribes 10mg bd. Two doses administered.	Drug charts	160, 164, 178	

	Now commenced on 10mg MST bd. Walked with physiotherapist this am but in a lot of pain. Physio demonstrated how to get Enid from chair onto zimmer frame (p98). *Both wounds redressed (p106).*	Nursing care plan	98, 106	
1/4/99	Reviewed by physiotherapist. *Please nurse Mrs Spurgin on bed over weekend rather than in chair, but she will need to walk x 2 daily using frame.*	Physio notes	116	
	Wound in right hip oozing large amounts of serous fluid and some blood. Hole noted in wound (p91). *Still having pain on movement (p98).*	Nursing care plan	91, 98, 106	
	Drug charts indicate: • MST: Two doses of 10mg administered.	Drug charts	178	

2/4/99	Drug charts indicate: • MST: Two doses of 10mg administered.	Drug charts	178	
3/4/99	Drug charts indicate: • MST: Two doses of 10mg administered.	Drug charts	178	
	MST 10mg bd continued. Still continues to complain of pain on movement (p98).	Nursing care plan	98, 150	
4/4/99	*Wound on R hip oozing serous fluid and blood. Steri-strip in situ at present (p100).* *Dressings renewed. No new leakage seen, dry dressing reapplied (p102).*	Nursing care plan	100, 102, 106	
	Drug charts indicate: • MST: Two doses of 10mg administered.	Drug charts	178	

5/4/99	Drug charts indicate: • MST: Two doses of 10mg administered.	Drug charts	178	
6/4/99	Reviewed by Dr Barton. *Shaw: Seen by Dr Barton. MST increased to 20mg. Nephew has visited, if necessary once Enid is discharged home (she is adamant about not going to a nursing home) he will employ someone to live in. Enid has been incontinent of urine a few times over the weekend. I have spoken to her about a catheter and she is going to think about it.*	Significant events	132, 134	
	Henning: Swabs taken from suture line rt hip and rt calf.	Nursing care plan	102	

	Drug charts indicate: • MST: 10mg administered. Dr Barton then prescribes 20mg bd. One dose administered.	Drug charts	178	
7/4/99	Reviewed by Dr Reid. *Still in a lot of pain and very apprehensive. MST ↑ to 20mg bd yesterday. Try adding flupenthixol. For x-ray R hip as movement still quite painful – also, about 2'' shortening R leg.*	Clinical notes	27	
	Commenced antibiotics as hip wound may be infected.	Nursing care plan	106	
		Significant events	134	
	Drug charts indicate: • MST: Two 20mg doses administered.	Drug charts	178	

8/4/99	Drug charts indicate: • MST: Two 20mg doses administered .	Drug charts	178	
	MST increased to 20mg bd (p98). *Wound oozing slightly overnight. Redness at edges of wound subsiding (p102).*	Nursing care plan	98, 102	
9/4/99	Drug charts indicate: • MST: Two 20mg doses administered.	Drug charts	178	
	To remain on bed rest until Code A *sees x-ray of hip (p98).* *Agreed to urinary catheter – very distressed when put onto commode earlier – urine very concentrated (p146).*	Nursing care plan	91, 98, 146	
		Significant events	134	

10/4/99	Drug charts indicate: • MST: Two 20mg doses administered.	Drug charts	178	
	Very poor night. Appears to be leaning to left. Does not appear to be as well and experiencing difficulty in swallowing. Stitchline inflamed and hard area. c/o pain on movement and around stitch line. Oramorph 5mg given at 07.15hrs (p91). *Waterlow score 31 (p110).* *Barthel 5 (p113).* *Enid not drinking despite encouragement + help (p146).*	Nursing care plan	91, 110, 113, 146	
11/4/99	Reviewed by Dr Barton. *Nephew telephoned at 19.10, as Enid's condition has deteriorated during this afternoon. She is very drowsy – unrousable at times. Refusing food and drink and asking to be left alone. Site round wound on rt hip red and inflamed. Asked about her pain, Enid denies pain when left alone, but complaining when moved at all. Syringe driver possibility discussed with nephew who is anxious that Enid be kept as comfortable as possible. S/B Dr Barton. To commence syringe driver.*	Significant events	134	

	Condition ill. Tolerating sips of oral fluids. Not anxious to be moved in any way. Did settle for long periods (p94). *Nelson: In pain on movement. Oramorph 5mg given at 07.15hrs (p98).* *Commenced antibiotics a few days ago. Wound not leaking today but hip feels hot and Enid c/o tenderness all round site. Enid very drowsy and irritable (p102).*	Nursing care plan	94, 98, 102, 146	
	Drug charts indicate: • Oramorph: 2.5ml (5mg) administered at 07.15. • MST: Two 20mg doses administered.	Drug charts	160, 178	
12/4/99	Reviewed by Dr Reid. *Now v drowsy (diamorphine infusion established). Reduce to 40mg/24hrs. If pain recurs, ↑ to 60mg. Able to move hip without pain, but pt not rousable!*	Clinical notes	27	

	S/B Dr Reid. Diamorphine to be reduced to 40mg over 24hrs. If pain recurs the dose can be gradually increased as and when necessary. Enid's nephew has been spoken to and is aware of the situation.	Significant events	136	
	Drug charts indicate: • Diamorphine: Dr Barton prescribes 20-200mg/24hrs by subcutaneous infusion. 80mg/24hrs administered at 08.00. • Hyoscine: Dr Barton prescribes 200-800µg/24hrs by subcutaneous infusion (in regular prescriptions, marked PRN). Not administered. • Midazolam: Dr Barton prescribes 20-80mg/24hrs by subcutaneous infusion. 30mg/24hrs administered at 09.00. • Cyclizine: Dr Barton prescribes 50-600mg/24hrs (precise dose range unclear) by subcutaneous infusion (in regular prescriptions, marked PRN). Not administered.	Drug charts	174	
13/4/99	Death recorded at 01.15.	Clinical notes Significant events	27 136	

	Cause of death: Cerebrovascular accident.	Death certificate		

GMC – v – Code A

CHRONOLOGY: PATIENT L – Code A

Date of Birth: 28/6/25

Date:	Event:	Source:	Page(s):	Comments:
2/2/99	Reviewed by locum consultant re left iliac fossa pain.	Correspondence Clinical notes	154 205	
9/3/99	Referred to consultant anaesthetist re abdominal pain.	Correspondence	144-145	

26/4/99	Admitted to Royal Hospital Haslar after experiencing chest pain and collapsing at home. CT brain scan conducted. *A&E referral. c/o L weakness. Had a fall whilst getting out of bed to go to toilet. Weakness L side. Has had chest pain all day. PMH: IHD – MI x 2 – AF, COPD/asthma, sigmoid resection. Chest clear. Abdomen soft. Imp: R sided CVA → L side weakness.* *WR: Complains for headache. L sided weakness. Speech slurred, gag reflex present. Plan: Chase blood results, urgent CT scan, LP if inconclusive, speech/language therapist r/v.* *CT result: No SAH or intracranial haemorrhage. Probable rt non-haemorrhagic infarction rt parietal lobe.* *SLT: Reduced but adequate movement. Will review 2-3 days.*	Clinical notes	208-211	

	Mobilising: Normally independent. Unable to stand O/A due to weakness (p96). *Mane: c/o headache & backache, pt states has arthritis in back.* *SCT: Swallow assessment. Drowsy but rousable. Back pain makes right posture difficult. Unable to produce [unclear] swallow. At risk of aspiration. Cont NG feed until review.* *AM: PR paracetamol given with poor effect. Analgesia needs reviewing.* *PM: NG feed in progress. c/o painful back, analgesia given with fair effect. Special mattress ordered (p98,100).* *Waterlow score 25 (p125).*	Nursing notes	92, 94, 96, 98, 100, 125, 131	
		A&E notes CT scan results Drug charts	146-149 255 73-78, 703-725	
27/4/99	Nasogastric tube feeding continues. *Apyrexial. L sided neglect. L facial weakness. L tongue deviation. ↑ tone L leg. Plantar ↑ L. Plan: Continue. Tolerating NG feeding.*	Clinical notes	212	

		Intake notes Nursing notes	51-68 100	
28/4/99	Transferred to Coronary Care Unit. Chest x-ray conducted. Antibiotics commenced. *Feels lousy today. L facial. L neglect. L weakness arm and leg. Speech improving.* *16.45: Pt has ? chest and L arm pain. Has had similar pain since Sunday morning. 2 x MI in past – different sort of pain. Tender over sternum on palpation. No response to GTN spray. ECG much as on admission ? [unclear] MI. ? MI over W/E. Now ? angina as tachycardic (?) due to ↓ digoxin dose. ? postural related, due to turning difficulties.*	Clinical notes	213-215	

	Feed continues by NG tube. *PM: Co-codamol given twice for a headache.* *Nocte: Turned 2 hourly as complaining of being very uncomfortable. Analgesia given for headache (p100).* *Transferred to CCU.* *ECG performed, ST elevation resolving slowly but still present. In AF, rate 90-100bpm.* *Complaining of back pain – oral analgesia given via NG tube.* *No chest pain (p108).*	Nursing notes	100, 108	
29/4/99	Reviewed by SHO. *Pain free for the first time this am. Mouth dry. Swallowing needs reassessing. Plan: Transfer to Ab. ? for nitrate.*	Clinical notes	216	
30/4/99	*Awake. Dense L hemiplegia present. ECGs confirm [unclear] MI on 28/4/99. No further chest pain. Chest clear.*	Clinical notes	216	

	Reviewed by HO on call. *Pt "bubbly" this pm. Suction no effect. Pt ° gag reflex and NG tube down. ? aspiration. OE: Distressed ++. Sats 80% on 10cl O_2. Widespread course crept. all lobes. Ankle oedema. Imp: ?aspiration pneumonitis +/- fluid overload. ABG: Type 1 resp failure.* *CXR: No NG tube seen but NG tube in! On RO NG tube this was found to be in nasal cavity, therefore feed has been placed directly down nasopharynx therefore can't exclude aspiration.*	Clinical notes	217-218	
1/5/99	Reviewed on ward round. *O_2 98%. Consolidation at L base course crept. Continue Ab.*	Clinical notes	219	
2/5/99	Reviewed by physiotherapist. *Being treated with [unclear] hands on + nasal suctioning with NR continuing. Improving.*	Clinical notes	219	

3/5/99	Reviewed on ward round. *ATSP re feeding. Can swallow water. To try thickened fluids.*	Clinical notes	219	
4/5/99	Reviewed on ward round and by dietician. *Still not speaking. Speech therapy to assess gag reflex. SLT: Swallow assessment. Adequate range of movement. Rec puree diet + thickened fluids.*	Clinical notes	219, 223	
5/5/99	Patient begins taking food orally. Referred to Code A consultant geriatrician. *To start foods as directed by speech therapist. Some residual weakness + sensory inattention but improving. Referral to Dr Lord: Could you give your opinion as to best path for rehabilitation of this 73 y o female. She is improving slowly. Nothing more we can do for her on acute medical side.*	Clinical notes	224	

	Treated with oxygen and diamorphine for respiratory failure. *Now aspiration pheumonia + in respiratory failure. Poorly ++. In distress. Plan: Still for resus, not for ventilation, O_2, Physio, small doses of diamorphine to keep comfortable, CXR.*	Clinical notes	225	
	AM: Remains very chesty. For thickened fluids and puree diet. Nasopharangeal suctioning administered, small effect. For chest physio this pm. *PM: Physio seem – NBM again. Still having problems with IVI going slow. 2.5mg IV diamorphine, pt agitated and complaining of discomfort/non-specific – unable to position her comfortably. S/B physio – aspirating fluids/softened diet therefore NBM until further review.* *Nocte: Family spoken to. Aware of poor prognosis. Remains for 444. Condition remains very poor.*	Nursing notes	110	
		Intake notes	44-50	

6/5/99	*Discussed with consultant. Not for resuscitation. Fluid overloaded. Bibasal creps. Plan: 80mg frusemide, IVI.* *SLT – remains NBM.* *Dietician: In view of NBM, recommend NG feeding recommenced.*	Clinical notes	226-227	
	Reviewed by Dr Lord. *Admitted with left hemiparesis and anterior myocardial infarct as well as atrial fibrillation. CT scan confirmed right parietal infarct. Also asthmatic and has had sigmoidcolectomy. Extremely unwell. Very dense left hemiplegia, left ventricular failure and aspiration pneumonia. Swallow not safe. On intravenous fluids. Too unwell for transfer to GWMH. Overall prognosis poor. If Mrs Stevens survives and is stable next week, happy to take her to slow stream stroke care bed at GWMH towards end of next week.*	Correspondence	734	
	Dr Lord notes: Suggest: (1) ↓ Total fluids to 1½l /day (2) Salbutamol nebs if wheezy (3) Diamorphine if distressed (4) Not for NG/PEG feeding (5) If stable early next week for transfer to slow stream stroke care GWMH later in the week.	Clinical note	228	

	Remains poorly. Needs regular suction. IV diamorph given as px. *PM Condition remains poor. Not for resuscitation.*	Nursing notes	110, 112	
7/5/99	Reviewed by Registrar. *Pt ° further deterioration. Obs stable. Plan: For 1½l fluid restriction daily, not for PEG, stop Ax, not for active blood tests, continue.*	Clinical notes	229	
10/5/99	Reviewed on ward round. Nasogastric feeding recommenced. *Pt improved. Obs stable. Plan: CXR, Dr Lord [unclear] feeding.*	Clinical notes	229-230	

	Reviewed by Dr Tandy, consultant geriatrician. *Appeared to improve over weekend. Barthel is zero. Has dense flaccid hemiparesis with very dysarthric speech. Can only obey simple commands. Tolerating NG feeds so far (this morning). When I arrived on ward she developed further central chest pain. Don't think stable enough to transfer to GWMH at present.*	Correspondence	69	
	Dr Tandy notes: Please normalise sodium, rule out MI, make sure tolerating NG. If above OK, please transfer to GWMH next week.	Clinical notes	230-232	
	Reviewed on ward. *15.50: ATSP re chest pain. Central chest pain. Looks unwell. Relieved after 4 sprays of GTN. ECG much as 4/5/99.* *16.10: Pain settled. Further escalation in treatment appropriate.*	Clinical notes	232-233	

	Nocte: NG tube feeding continues. Bottom and perineum very sore and peeling.	Nursing notes	114	
		Intake notes	32-43	
11/5/99	Reviewed by SHO and SLT. *c/o chest pain. Obs stable. Plan: Continue NG feeding, small amounts of thickened fluids orally, put nitrates through NG tube for chest pain, not for 444.* *SLT: Tolerated small amounts of thickened fluid.*	Clinical notes	233-234	
12/5/99	Reviewed on ward round. *Feeding well through NG tube. c/o chest pain, relieved by GTN. Obs stable.* *Spoke to Mrs Stevens' husband and daughter. Explained prognosis and rationale behind why pt would be allowed to die naturally, rather than be resuscitated or put on ITU, if she had a further MI or respiratory failure/arrest.*	Clinical notes	234	

13/5/99	Reviewed on ward round, and by dietician. *Pt worse this am. Plan: Bloods, continue with good skin care, continue rehabilitation.*	Clinical notes	235	
14/5/99	Reviewed by orthopaedic specialist. Subluxation of shoulder diagnosed. *Pt worse this am. Obs stable.* *Orthopaedics: This is an inferior subluxation. No [unclear] intervention needed.*	Clinical notes	236	
	Nocte: Very uncomfortable this evening. Diamorphine 5mg S.C. given to assist settling with good effect.	Nursing notes	118	
		Drug charts	73	

15/5/99	*Full bed bath given. Appears more weary this pm. Diamorphine 5mg S.C. given with good effect.*	Nursing notes	120	
		Drug charts	73-78	
16/5/99	*AM: Care continues as plan. No incontinence this am. Settled and slept very well without diamorphine. Feed continues as per regime.*	Nursing notes	120	
		Drug charts	73-78	
17/5/99	Reviewed by SHO, and by dietician. *Pt no real change. ° further pyrexia since 14/5. Creps L base. P: Continue, check bloods.* *Tolerating feeds without any problems. Bowels now open. Continue.*	Clinical notes	237	

	Paracetamol given with effect. Feed continues. Very demanding overnight. Continues to disturb other patients with calling out.	Nursing notes	120	
		Drug charts	73-78	
18/5/99	Reviewed on ward round. Liaison between Royal Haslar Hospital and GWMH. *Pt sitting in chair. Obs stable.* *Blood test results.* *Liaised with GWMH. Happy to take Mrs Stevens with above results. Tolerating NG feeding well. Seems to have recovered from aspiration pneumonitis. Slow improvement in orientation, speech and strength. Still faecally incontinent and requires catheter in situ.*	Clinical notes	237-238	

	Hoisted into bath this morning. Still c/o general aches + pains despite regular co-dydramol.	Nursing notes	120	
		Drug charts	73-78	
19/5/99	Reviewed by physiotherapist. *Referred for collection of sputum sample, but no added sounds and has poor cough. Nasopharangeal suctioning not indicated, so sample not obtained. To monitor.*	Clinical notes	238-239	
	Settled and slept all night.	Nursing notes	122	
		Drug charts	73-78	

20/5/99	Transferred to Daedalus Ward, GWMH. Upon transfer, patient receiving aspirin, enalapril, digoxin, isosorbide, mononitrate and PRN subcutaneous diamorphine 5mg. *Diagnosis and treatment in hospital: Stroke. For rehab at Gosport WMH.*	Transfer record	70-71	
	Admitted following R CVA 26/4/99. Dense left hemiplegia unresolved. Recovery affected by MI 28/4/99. Now remains with dense L hemiplegia with no swallow. Catheter in situ. Faecally incontinent. History of angina and IBS. Has had aspiration pneumonia, now resolved. All care required with all ADLs. NG feeding. Pressure areas intact though very sore in groin area – improving with sudacrem. Diarrhoea at present.	Nursing referral	86	

	Neville: Transferred from Haslar today, following R CVA on 26/4/99. Had been at home complaining of chest pain all day, then collapsed. Whilst in Haslar had possible MI on 28/4/99 – confirmed by ECG. NG feed required due to poor gag reflex. Speech slurred slightly but Code A *appears quite alert of surroundings. Has a dense L weakness. Catheter in situ. Faecally incontinent.*	Significant events	1299	
	Reviewed by Dr Barton. *Transfer to Daedalus Ward 555K. HPC: R cva 26-4-99. Dense L hemi. Aspiration pneumonia and MI 28-4-99. PMH: IHD MI x 2, AF, COPD asthma, sigmoid resection. Barthel: Needs help with ADL, catheterised, ng tube in situ, transfer with hoist, Barthel 0.*	Clinical notes	1292	

Code A

	Unable to answer on O/A. But husband says whilst in Haslar she knew she had been unwell. Poor hearing in R. Poor vision – wears glasses most of the time. Speech slow and slurred at times. Orientated. Diet: NG feeds. Pain: c/o abdo pain due to history of bowel problems. Oramorph given O/A (p1302). *Waterlow score 25 (p1304).* *Barthel 1 (p1306).* *Abbreviated mental study score 4 (p1307).* *Neville: Slurred speech. Compliant. Pain: Abdo pain. Skin dry, intact (p1318).* *Nutritional assessment tool score 20, at high risk (p1322).*	Nursing assessment	1302-1307, 1318-1322	
	Requires assistance to settle and sleep at night. Oramorph 2.5mls (5mg) given. c/o pain in stomach and arm. Condition poor (p1337).	Nursing care plan	1324-1337	
		Nursing notes (Haslar) Admission notes	122 1296-1297	

	Drug charts indicate: • Digoxin: Dr Barton prescribes 1.2ml od. • Enalapril: Dr Barton prescribes 5mg od. • Aspirin: Dr Barton prescribes 75mg od. • Isosorbide: Dr Barton prescribes 60mg. Not administered. • Suby C: Dr Barton prescribes. Not administered. • Oramorph: Dr Barton prescribes 2.5-5ml (5-10mg) PRN. 2.5ml (5mg) administered at 14.30, 18.30 and 22.45. • Diamorphine: Dr Barton prescribes 20-200mg/24hrs PRN by subcutaneous infusion. • Hyoscine: Dr Barton prescribes 200-800µg/24hrs PRN by subcutaneous infusion. • Midazolam: Dr Barton prescribes 20-80mg/24hrs PRN by subcutaneous infusion.	Drug charts	1342-1346	

21/5/99	Drug charts indicate: • Digoxin: 1.2ml administered. • Enalapril: 5mg administered. • Aspirin: 75mg administered. • GTN spray: Dr Barton prescribes 2 puffs PRN. Not administered. • Oramorph: 2.5ml (5mg) administered at 07.35. Dr Barton then prescribes 5ml (10mg) four times daily and 10ml (20mg) nocte. 5ml (10mg) administered at 10.00 and 14.00. • Diamorphine: 20mg/24hrs administered at 19.20. • Midazolam: 20mg/24hrs administered at 19.20.	Drug charts	1342-1346	
	11.30: To have GTN spray PRN. Now on regular (4 hourly) oramorph 10mg/5ml. *Beed: 18.00: Uncomfortable throughout afternoon despite 4hrly oramorph. Husband seen & care discussed, very upset. Agreed to commence syringe driver for pain relief at equivalent dose to oral morphine with midazolam. Aware of poor outlook but anxious that medications given should not shorten her life.* *Beed: 19.45: Commence syringe driver.*	Contact record	1309	

	Turnbull: Remains poorly but comfortable.	Nursing care plan	1337	
22/5/99	Drug charts indicate: • Diamorphine: 20mg/24hrs administered at 08.00. 20mg/24hrs administered at 10.30. • Hyoscine: 800µg/24hrs administered at 08.00. Dr Beasley then verbally prescribes 1600µg/24hrs by subcutaneous infusion. 1600µg/24hrs administered at 10.30. • Midazolam: 20mg/24hrs administered at 08.00. 20mg/24hrs administered at 10.30.	Drug charts	1342-1346	
	08.00: Condition has deteriorated. Very bubbly. *10.20: Still very bubbly. Dr Beasley contacted and verbal order to increase hyoscine to 1600mcg.*	Contact record	1309, 1311	
	Death recorded at 22.30.	Clinical notes Significant events Contact record	1292 1299 1311	

Code A

GMC – v – DR JANE BARTON

CHRONOLOGY: PATIENT D – ALICE WILKIE

Date of Birth: Code A

Date:	Event:	Source:	Page(s):	Comments:
31/7/98	Admitted to Queen Alexandra Hospital, Department of Medicine for Elderly People, from care home with unresolved urinary tract infection. *Admitted via GP from care home with unresolved UTI, decreased mobility, pyrexia. Incontinent of urine x 2 since admission. Could the daughter be informed as soon as Alice is seen by doctor.*	Clinical notes	98A	
	PC: Demented lady. Has been in psychogeriatric care home for 1yr. UTI early this week, has not responded to antibiotics. Barthel = 1. Pyrexial.	Clinical notes	166-168	
	Catheterised due to incontinence of urine.	Nursing notes	105	

	Communication very poor. Suffers from dementia. Mobilises with lots of encouragement. Some pain in abdomen.	Handling profile	118	
		Referral letter	150	
	Drug charts indicate: • Promazine syrup: Dr Wilson prescribes 25mg PRN. Not administered. • Dr Wilson also prescribes as regular prescriptions fluoxetine (Prozac), co-danthramer, zopiclone, lactulose and promazine.	Drug charts	139, 142	
1/8/98	*81yr old lady with advanced dementia. In Addenbrooke House 1yr. Admitted with pyrexia. UTI did not respond to [unclear]. Plan: Continue with [unclear]. Encourage oral fluids.*	Clinical notes	169	

	Slept all night. Catheter draining. Full wash given. Dressed and sitting in chair, food and fluids encouraged. *19.30: Quiet afternoon. Needs plenty of encouragement with food and fluids.*	Nursing notes	105	
	Drug charts indicate: • Haloperidol: Code A prescribes 2.5-10mg PRN, max 60mg/24hrs. 2.5mg administered at 20.45. • Augmentin: Code A prescribes 1.2g iv tds. Two doses administered. Replaced with augmentin elixir from 2/8/98.	Drug charts	139, 144	
		Care plan	107-113	

4/8/98	Reviewed by Dr Lord. *MTS 0/10 – usually quiet and withdrawn.* *Barthel 1/10.* *CXR and ECG – NAD.* *Catheterised – RV 500mls.* *Pressure areas vulnerable.* *Plan: Continue oral augmentin. SC fluids. Overall prognosis poor + too dependent to return to Addenbrooke's. Transfer to Daedalus continuing care on 6/8/98 am → for 4-6/52 observation + then decide on placement. Keep bed at Addenbrookes. DNR.*	Clinical notes	98A, 99A	
	Drug charts indicate: • Magnesium hydroxide: **Code A** prescribes 10mls PRN. Not administered.	Drug charts	139	
		CPN notes	302	

6/8/98	Transferred to Daedalus Ward, GWMH. *Transferral from Phillip Ward for 4-6/52 obs. On augmentin for UTI.*	Clinical notes	99A	
	Admitted to QAH for UTI, pyrexia and dehydration. Past medical history: Dementia. Too dependent to return to Addenbrooke's Rest Home. For 4-6 week observation then decide on placement. Oral antibiotics for UTI. Waterlow 16. Barthel 2. Fluid intake still being supplemented with sub cut fluids. Mentally she is dependent and needs feeding. Pressure areas intact.	Referral letter	148	
	Slept very well. S/cut fluids continued. For Dryad Ward Gosport today. Assisted with washing and dressing. Catheter draining poor.	Nursing notes	116	
	Due to restricted mobility, Waterlow Score 15.	Nursing care plan	212	

	Joice: Transferred from Philip Ward QAH for 4-6 weeks assessment and observation + then decide on placement. Medical history of advanced dementia, urinary tract infection and dehydration.	Significant events	196	
	Visited on Daedalus Ward. Daughter was also there. Alice has a Barthel of 1 at present. Alice did require haloperidol @ QAH for the 1st few days there. I will contact ward in 3-4 weeks time.	CPN notes	303	
		Discharge plan	96	
10/8/98	Reviewed by Dr Lord. *Barthel 2/20. Eating and drinking better. Confused and slow. Give up place at Addenbrookes. R/W in 1/12 – if no [unclear] medical or nursing problems D to a N/Home.*	Clinical notes	99B	

12/8/98	*Alice on Daedalus Ward, physically unchanged. Very needy, not expected to return to Addenbrooke.*	CPN notes	303	
17/8/98	Deterioration recorded. *Condition generally deteriorated over the weekend. Daughter seen – aware than mum's condition is worsening, agrees active treatment not appropriate & to use of syringe driver if Mrs Wilkie is in pain.*	Contact record	206	
	Nutrition: Small amount of Ensure plus taken.	Nursing care plan	210	
Undated	Drug charts indicate: • Diamorphine: Dr Barton prescribes 20-200mg/24hrs by subcutaneous infusion. • Midazolam: Dr Barton prescribes 20-80mg/24hrs by subcutaneous infusion. • Hyoscine: Dr Barton prescribes 200-800µg/24hrs by subcutaneous infusion.	Drug charts	145	

20/8/98	Drug charts indicate: • Diamorphine: 30mg/24hrs administered from 13.50. • Midazolam: 20mg/24hrs administered from 13.50.	Drug charts	145	
21/8/98	Entry in clinical notes by Dr Barton. *Marked deterioration over last few days. SC analgesia commenced yesterday. Family aware and happy.*	Clinical notes	99B	
	Joice: 12.55: Condition deteriorating during morning. Daughter and granddaughters visited and stayed. Patient comfortable and pain free.	Contact record	206	
	Drug charts indicate: • Diamorphine: 30mg/24hrs administered. • Midazolam: 20mg/24hrs administered.	Drug charts	145	

	Death recorded at 18.30.	Clinical notes Contact record	99B 206	

GMC – v – DR JANE BARTON

CHRONOLOGY: PATIENT H – ROBERT WILSON

Date of Birth: Code A

Date:	Event:	Source:	Page(s):	Comments:
17/2/97	Admitted to Queen Alexandra Hospital with epigastric pain. Diagnosed with alcoholic liver disease. Discharged on 5/3/97. *Presented with 1½hr history of epigastric pain. Relieved by vomiting. No haematemesis. At least one previous episode 6 months ago. Drinks a lot. On examination, he was comfortable, pitting oedema to thigh, large sacral pad. Some bi-basal crackles. Abdomen tense but not tender. No masses palpable. Full blood count was abnormal with white cell count of 20. ECG showed rate of 75 in sinus rhythm with poor R wave progression. Chest x-ray showed increased shadowing in left zone. Liver function tests abnormal. Admitted, difficult to treat as uncooperative. Antibiotics given. Started on diuretics. Small bright liver ? cirrhotic with marked ascites in the gut. Liver function increased a little. Abdominal pain settled. Discharged home.*	Discharge summary	130	

		Clinical notes Nursing notes	148-157 395-399	
21/9/98	Attends A&E at Queen Alexandra Hospital by ambulance, following a fall, fracturing left humerous. *Pt fallen over forward onto left shoulder. Pt drank ETDH whisky. c/o pain & unable to move left arm. X-ray shoulder fractured humerous. Plan: Advice, sling, review, if OK socially home, clean and dress forearm, discharge → fracture clinic.*	Clinical notes	158-162	
		A&E notes	126-128	

22/9/98	Admitted to ward, Queen Alexandra Hospital. Reviewed by [Code A], registrar in trauma and orthopaedic surgery. *Diagnosis: Left greater tuberosity fracture. Assessed in fracture clinic. Sustained injury when fell. X-ray reveals some displacement of the fragment. Not keen to undergo surgical intervention. Aware that he will have restricted range of movement. Will review in two weeks time.*	Correspondence	142	
	Plan: Observe for vomiting. Analgesia (p160). *Pt adamant he will cope at home. Very unsteady on his feet. Vomiting. Transfer to Dickens Ward (p164).*	Clinical notes	160, 164	
	Lives with wife in 2 bedroom house. Usually independent. [Code A] *Admits to x6 double whiskeys/day.* *07.10: Pt prescribed IV morphine for analgesia therefore paracetamol given as nurse prescription (p26).*	Nursing notes	10-12, 26	

	Very poor appetite. Skin: Couple of small breaks from fall. Complains of a great deal of pain – dislikes being touched on R side. Needs help dressing.	Nursing care plan	40	
23/9/98	*02.30: S/B SHO. For morphine & cyclidine (prescribed IV).* *AM: Morphine is now SC injection and codeine phosphate has been added. Was administered this morning for pain.* *Mrs Wilson has contacted the ward. She will be returning from holiday on Sunday and will contact us again (p12).* *Pt refused wash, complains of pain/severe discomfort – given codeine (p26).* *Barthel 13 (p70).* *Waterlow score 7 (p72).*	Nursing notes	12, 26, 70, 72	
	L arm in sling. Painful to touch and painful on movement. Summary: 75 year old, left fractured humerus, vomiting, pain, alcohol, apyrexial, painful L arm. *Analgesia: Not helped by present pain relief so try morphine 2-5mg IV.*	Clinical notes	166-169	

	Paracetamol 1g administered. Codeine phosphate 30mg administered twice. Morphine 5mg administered.	Drug charts	106	
24/9/98	*Experiencing severe pain this morning. Addressed with diamorphine. Also lost sensation and movement in left hand. Referred to fracture clinic urgently. By time he attended, symptoms diminished. Now has sensation and movement (p12).* *06.15: Complaining of pain in L arm, diamorphine 2.5mg given with little effect. Diamorphine 2.5mg s/c given @06.50.* *10.30: States pain not as bad as early morning. Bioclusive applied to skin tears on L arm. Cooperative despite obvious pain from fracture. Poor nutritional intake (p26-27).*	Nursing notes	12, 26-27	
	C/o left forearm ↓ sensation, pain left shoulder → elbow. Diamorphine 5mg given in last 1hr. On arrival, more settled → effect of diamorphine. V painful from shoulder to elbow. Plan: Regular analgesia.	Clinical notes	170-171	

	Compliance good, hard of hearing. Pain +++ from L fractured humerus. Skin tears to L arm. Independent gentleman normally.	Handling profile	68	
	Morphine 2.5mg administered twice. Codeine phosphate 30mg administered three times.	Drug charts	106	
25/9/98	*Regular analgesia prescribed + aperients (p13).* *Very withdrawn c/o pain in back of neck. Extensive bruising to inner aspect of lower arm (p27).*	Nursing notes	13, 27	
	Drowsy. Sit → stand with 1. ↓ balance.	Physio notes	290	
	Codeine phosphate administered once. Codydramol administered three times.	Drug charts	106, 114	

26/9/98	*Barthel 10.*	Nursing notes	70	
	Codydramol administered four times.	Drug charts	114	
27/9/98	*Wife returned from holiday, made clear she would be unable to care for husband in present condition. Explained concerns centred around poor nutrition, improving pain control, rehabilitating him, monitoring healing fracture (p13).* *Not eating great amounts. Very lethargic + disinterested. Still very sleepy this PM. Encourage diet and fluids. Pain remains bad in L humerus. Nocte: Appears comfortable with regular analgesia (p28-29).*	Nursing notes	13, 28-29	
	Codydramol administered four times.	Drug charts	114	

28/9/98	*Two sons visited. Very concerned. Only just found out about hospitalisation. Commenced on IV fluids (p13). Arm remains extremely bruised, swollen and tender. Remaining sleepy and uncooperative (p29). Barthel 7 (p70).*	Nursing notes	13, 29, 70	
	Note renal function deteriorates. Dehydrated. Stop diuretic. IV fluid.	Clinical notes	171	
	Drowsy. Sit → stand with 2. Mob short distance with 2.	Physio notes	270	
	Codydramol administered four times.	Drug charts	114	

29/9/98	*S/B* Code A *Will be reviewing resuscitation status. Says medically there is little more to be done. May need nursing home placement. IV fluids continue (p14).* *11.00: Able to left his L arm quite well without any pain. Managed to wash own face and front top half. Skin tear to inner aspect of R wrist granuflex applied. All other pressure areas intact. Sat out in chair. Asleep for most of afternoon. Not eating and drinking this pm. Nocte: Settled well with analgesia (p29-30).*	Nursing notes	14, 29-30	
	Impaired renal function. Alcoholic hepatitis. Hypothyroid. Review resusc status. Not for resuscitation in view of poor quality of life and poor prognosis.	Clinical notes	172	
	Codydramol administered three times.	Drug charts	114	

30/9/98	*Top of left arm oedematous, weeping in small areas. Reviewed by Dr Ravi – cont IV + stop sedation. Left arm remains very swollen and exuding serous fluid. Remains drowsy (p15).* *Appetite remaining extremely poor. Full assistance required with all ADLs. Restless night. Complaining of pain in L arm, says the tablets are inadequate (p30-31).* *Waterlow score 18 (p72).*	Nursing notes	15, 30-31, 72	
	Renal function better. Still drowsy.	Clinical notes	172	
	Codydramol administered once. Paracetamol 1g administered three times. Prescribed four times daily from this point until discharge. Frequently refused by patient.	Drug charts	114	

1/10/98	*Robert states he is desperate for sleep, tends to be awake at night and asleep during day (typical of alcohol withdrawal) therefore chlordiazepoxide 10mg written for 21.00 nocte (p15-16).* *L arm painful +++ on movement. No c/o pain at rest. Pt v sleepy. IVI continues. Appetite poor. Nocte: Discomfort continues. Analgesia spat out. Up in chair from midnight (p31).*	Nursing notes	15-16, 31	
	Paracetamol 1g administered three times.	Drug charts	114	
2/10/98	*Consultant review: Discontinue IV fluid, encourage oral fluid. High protein diet. Psychogeriatrician referral. To be put on continuing care list (p16).* *L arm remains painful on movement. Transferring with help from two nurses. Sat out in chair. Nocte: Refused analgesia. Arm looks swollen and blistered (p31-32).* *Barthel 3 (p70).*	Nursing notes	16, 31-32, 70	

	Still very sleepy. Awake at night. Oedematous. Low alb. Chest crepts. Stop IV fluid. Encourage protein drink. Referred to psychogeriatrician. *S/B dietician: Poor nutritional intake. High protein diet. Encourage with supplement drinks. Possible NG tube.*	Clinical notes	173-174	
	Paracetamol 1g administered once.	Drug charts	114	
3/10/98	*Discomfort continues on movement. Transfer to commode with two nurses. Pressure area to sacrum red but intact. PM: Walked to toilet with help from family and staff. Nocte: Boarded for morphine 2.5mg IM for painful arm because oral analgesia refused. Given at 23.10 with good effect. Settled and slept.*	Nursing notes	32	
	Morphine 2.5mg administered.	Drug charts	107	

4/10/98	*Left arm remaining extremely painful + bruised. Does not tolerate sling. Arm elevated on pillow (p17).* *Full assistance with washing and dressing. Intake poor. Still in great pain due to fracture. PM: Incontinent of faeces. Standing quite well with help from 2 nurses. Fair amount of fluid taken. Quite alert and chatty. Nocte: Refused paracetamol, states not worth taking. Morphine 2.5mg given 02.00 as unsettled and uncomfortable (p33).*	Nursing notes	17, 33	
	Paracetamol 1g administered twice.	Drug charts	114	
5/10/98	*Knocked left arm this afternoon, causing small laceration. Fluid leaked from wound. Opsite applied (p17).* *AM: Not very alert. PM: Very alert and orientated. Transferring well with 1 person. Drinking well, eating well. Nocte: Speech clearer, some discomfort at times, still refusing paracetamol (p34).* *Waterlow score 15 (p72).*	Nursing notes	17, 33-34, 72	

	Morphine 2.5mg administered.	Drug charts	107	
6/10/98	*Reviewed by medical team. Continue fortisips. Increase protein intake. Plan N/Home care as Barthel ↑ 5. OT care management requested.* *S/B Dietician: Nutritional intake slightly improved. Continue with high protein diet and supplement drinks (p17-18).* *PM: Comfortable afternoon. No complaints. Nocte: Incontinent of faeces. Sat out in chair for short periods. Taking prescribed analgesia for pain in arm with only small effect (p34).* *Barthel 5 (p70).* *Medication: Thiamine, multivitamins, senna, magnesium hydroxide, paracetamol QDS (p76)*	Nursing notes	17-18, 34, 70, 74, 76	
	Still in pain in L arm. Obs OK. Plan: Paracetamol → soluble, ? add codeine. *S/B dietician: Intake has improved but still below requirements.*	Clinical notes	175	

	Paracetamol 1g administered twice.	Drug charts	114	
7/10/98	*S/B physio. More alert today. Mobilised at 8am with 2 to assist. Wishes to return home (p18). Uncomplaining. Soluble paracetamol as prescribed (p34).*	Nursing notes	18, 34	
	Left arm remains bruised and sore. Bioclusive applied to left hand, as puffy and slightly torn skin.	Nursing care plan	50	
	Brighter, talking well, eating and drinking. Obs fine. Still some swelling L hand/arm.	Clinical notes	175	
	Much brighter today. Sit → stand with 2. Mob 10m with 2. Shuffling gait.	Physio notes	291	

	Paracetamol 1g administered four times.	Drug charts	114	
8/10/98	Reviewed on Dickens Ward by Code A in old age psychiatry. *During current admission had become rather sleepy and withdrawn and low in mood. Had raised MCV, impaired renal function, active alcoholic hepatitis and hypothyroidism. Was treated with IV fluids and gradually improved. Now eating and drinking well, appears much brighter in mood. Appeared calm, friendly and cooperative. Speech coherent. Low in mood, easily tearful but able to smile. Full orientation in place, partial orientation in time and mildly impaired short term memory. MMSE was 24/30. Physically obese. Left hand grossly swollen and bruised. Marked oedema of both legs. Mobility remains poor. May have developed early dementia. Might be early Alzheimer;s disease of vascular type dementia. Also depression. Suggest trazodone.*	Correspondence	117-118	
	Code A s notes.	Clinical notes	176-177, 420-425	

	Eating and drinking. Obs fine. Swelling still sore.	Clinical notes	176	
	S/B OT – refusing to wash for 2nd day running. No longer requiring acute bed. At risk of self injury, hand very very oedematous + at risk of breakdown due to lue albumen (p19). *No problems. Eating well. Elbow and cuff in situ arm remaining swollen although less today. Refused wash. Very chatty and funny. Hand remains very red and oedematous. Sacral cleft quite red with penile discharge. Ankles very oedematous and tender. Appetite variable. Paracetamol given as prescribed. Nocte: Asked doctor to consider stronger analgesia, now prescribed codeine phosphate prn (p34-35).*	Nursing notes	19, 34-35	
	Pain: Remains bruised and swollen – quite painful (p46). *Hygeine: Very oedematous ankles. Reluctant to participate in early morning but more cooperative later. Requires full assistance. Buttocks very re in anal crease. Scrotum oedematous and penis red with discharge (p48).*	Nursing care plan	46, 48	

	Bright and alert. Sit → stand with 2. Mob 15m with 2.	Physio notes	291	
	Codeine phosphate 30mg administered. Paracetamol 1g administered four times.	Drug charts	107, 114	
9/10/98	*Social work assessment. Mr Wilson's need indicate nursing home placement on discharge. Soc Serv will not fund short stay in N.H. and can we look at SCH/GWMH?* *Doctor informed of patient's penile discharge and ulceration (p21).* *Still talking about going home. Had visitors all afternoon. Chatty and appears well. Has some pain – slightly ulcerated with discharge (p36).*	Nursing notes	21, 36	
	Gross oedema. Eating well. Barthel 5. On trazadone and diuretics. For NH placement.	Clinical notes	177	

	Requires help with all activities of daily living. Discharge home is totally unrealistic. Collar and cuff in situ on L arm which is very oedematous and at risk of further injury. Placement recommended.	OT notes	182-183	
	Codeine phosphate 30mg administered. Paracetamol 1g administered four times.	Drug charts	107, 114	
10/10/98	*Tried to put forward for continuing care bed, but not accepted because Barthel too high at 7. Appropriate for rehab (p22).* *Good night's sleep. PRN codydramol now prescribed although no extra analgesia required overnight (p36).*	Nursing notes	22, 36	
	Paracetamol 1g administered four times.	Drug charts	114	

11/10/98	*A bit clearer with speech. Good diet taken. Pain remains quite bad in L arm. Managed to shave himself. Transferring much better today. Nocte: Drinking well. Appears comfortable with regular analgesia (p36-37). Barthel 7 (p70). Waterlow score 15 (p72)*	Nursing notes	36-37, 70, 72	
	Paracetamol 1g administered four times.	Drug charts	114	
12/10/98	*Remains in a lot of pain when being cared for. Nocte: Drinking well. Arm, hands and feet remain swollen and very uncomfortable.*	Nursing notes	37	
	WR SHO: Swelling in L arm seems better. Bit brighter today. → continuing care or rehab.	Clinical notes	178	
	Mobilisation chart.	Nursing care plan	56	

	Lying on bed reluctant to mobilise. Mob 15m with 2.	Physio notes	291	
	Codeine phosphate 30mg administered. Paracetamol 1g administered four times.	Drug charts	107, 114	
13/10/98	*Reviewed by medical team. Continues to require special medical/nursing care as oedematous limbs at high risk of breakdown. Foot R already about to breakdown. This is due to oedema secondary to cardiac failure and low protein (p22).* *Weight up to 114.4kg. In good mood this am. Remained in bed all pm. No complaints of any pain. Passing urine independently using bottle. Peaceful night (13^{th}-14^{th}). Slept well. No complaints of pain (p37-38).*	Nursing notes	22, 37-38	
		Clinical notes	178-179	

	Referral letter: Fractured left humerus. Has alcohol problems. Lives with wife in 2 bedroom house. Prior to admission was independent. Transfer for continuing nursing care needs. Barthel is 7. Still in a lot of pain in his arm and difficulty in moving. On high protein diet. Legs very oedematous, at high risk of breakdown secondary to cardiac failure and low protein. Needs 24hr nursing care. Medication: Paracetamol 1g QDS.	Referral letter	81	
	Refused to mobilise. Remains oedematous. *Transfer summary: Ensure L arm supported. Sit → stand practise with 2. Transfer practise with 2. Gait practise with 2. Plan: Continue with active movements, mobility and transfer practice.*	Physio notes	291-292	
	Codeine phosphate 30mg administered. Paracetamol 1g administered four times.	Drug charts	107, 114	
	Biochemistry report forms for QAH stay.	Analysis results	184-254	

14/10/98	Transferred to Dryad Ward, GWMH. Reviewed by Dr Barton. *Transfer to Dryad Ward continuing care. HPC: Fractured humerus L 27-8-99. PMH: Alcohol problems, recurrent oedema, CCF. Needs help with ADL. Hoisting. Continent. Barthel 7. Lives with wife Salisbury Green. Plan gentle mobilisation.*	Clinical notes	180	
	Hallman: Long history of heavy drinking. LVF. Chronic oedematous legs. S/B Dr Barton. Oramorph 10mg given. Continent of urine – uses bottles.	Significant events	266	
	Barthel 4 (p274). *Patient's understanding of condition: Fully comprehending. Bladder normal (p276).* *Restless at times. Used urinal with assistance as he wanted to stand. Oramorph 10mg given for pain control (p279).*	Nursing notes	274-283	

	Drug charts indicate: • Paracetamol: Dr Barton prescribes 1g every four hours PRN. Not administered. • Dr Barton also prescribes frusemide, spironolactone, bendrofluazide, trazodone, thiamine, multivitamins, magnesium hydroxide and senna.	Drug charts	259, 261-262	
Unclear	Drug charts indicate: • Hyoscine: A doctor other than Dr Barton prescribes 600µg/24hrs PRN by subcutaneous infusion "if requested." Not administered.	Drug charts	259	

Unclear	Drug charts indicate: • Oramorph: Dr Barton prescribes 2.5-5mls (5-10mg) four hourly PRN (written in regular prescriptions, those words crossed out and "PRN" written in). 10mg administered at 14.45 and 22.45 on 14/10/98. • Diamorphine: Dr Barton prescribes 20-200mg/24hrs PRN by subcutaneous infusion (written in regular prescriptions, those words crossed out and "PRN" written in). • Hyoscine: Dr Barton prescribes 200-800µg/24hrs PRN by subcutaneous infusion (written in regular prescriptions, those words crossed out and "PRN" written in). • Midazolam: Dr Barton prescribes 20-80mg/24hrs PRN by subcutaneous infusion (written in regular prescriptions, those words crossed out and "PRN" written in).	Drug charts	263	
15/10/98	*Shaw: Commenced oramorph 10mg 4 daily for pain in L arm. Wife seen by Sis Hamblin who explained Robert's condition is poor.*	Significant events	266	

	Settled and slept well. Oramorph 20mg given 12midnight with good effect. Oramorph 10mg given 06.00. Condition deteriorated overnight. Very chesty + difficulty swallowing medication. Incontinent urine ++ WSP to sore groins (p279). *Lyons: Bed bath. [Unclear] to groinds, penis + scrotum. Liquid paraffin to feet and legs (p283).*	Nursing notes	279, 283	
	Drug charts indicate: • Oramorph: Dr Barton prescribes 10mg four times daily. 10mg administered at 10.00, 14.00 and 18.00. Dr Barton also prescribes 20mg nocte. Administered at 22.00 then discontinued.	Drug charts	262	
16/10/98	Reviewed by Dr Knapman. *Declined overnight with SOB. O/E bubbling. Weak pulse. Unresponsive to spoken orders. Oedema in arms and legs. ? silent MI ? ↓ liver function. ↑ frusemide.*	Clinical notes	180	

	Seen by Dr Knapman am as deteriorated overnight. Increased frusemide to 80mg daily. For ANC. *Hallman: PM: Very bubbly chest this pm. Syringe driver commenced. Wife informed of patient's continued deterioration.*	Significant events	266	
	Has been on syringe driver since 16.30. A little bubbly at approx 22.30 when repositioned. More secretions = pharangeal – during the night, but Robert hasn't been distressed. Appears comfortable (p279).	Nursing notes	279, 283	
	Drug charts indicate: • Oramorph: 10mg administered at 06.00, 10.00 and 14.00. • Diamorphine: 20mg/24hrs administered at 16.10. • Hyoscine: 400µg/24hrs administered at 16.10.	Drug charts	263	
17/10/98	Reviewed by Dr Peters. *Comfortable but [unclear] deterioration. N/S to verify death if necessary.*	Clinical notes	180	

	05.15: Hyoscine increased to 600mcg as oro-pharangeal secretions increasing overnight. *Hamblin: PM: Slow deterioration in already poor condition. Requiring suction very regularly – copious amounts suctioned. Syringe driver renewed at 15.50 with diamorphine 40mg midazolam 20mg and hyoscine 800mcg.*	Significant events	266-267	
	05.15: Hyoscine increased to 600mcg as secretions increasing. During day diamorphine 40mg and hyoscine increased to 800mcg, midazolam 20mg added. Night: Noisey secretions but not disturbing Robert. Suction given as required during night. Appears comfortable.	Nursing notes	279	
	Drug charts indicate: • Diamorphine: 20mg/24hrs administered at 05.15. Then increased to 40mg/24hrs at 15.50. • Hyoscine: 600µg/24hrs administered at 05.15. Then increased to 800µg/24hrs at 15.50. • Midazolam: 20mg/24hrs administered at 15.50.	Drug charts	263	

18/10/98	*Hamblin: Further deterioration in already poor condition. Wife remained overnight. Syringe driver renewed at 14.50 with diamorphine 60mg midazolam 40mg and hyoscine 1200mcg. Continues to require regular suction.*	Significant events	267	
	Bed bath given, all cares continued (p283).	Nursing notes	279, 283	
	Drug charts indicate: • Diamorphine: 60mg/24hrs administered at 14.50. • Hyoscine: Dr Peters verbally prescribes 1200µg/24hrs by subcutaneous infusion. 1200µg/24hrs administered at 14.50. • Midazolam: 40mg/24hrs administered at 14.50.	Drug charts	263	
	Death recorded at 23.40.	Clinical notes Significant events	180 267	

	Cause of death: (I)(a) Congestive cardiac failure (b) Renal failure (II) Liver failure.	Death certificate		

GMC – v – DR JANE BARTON

CHRONOLOGY: PATIENT E – GLADYS RICHARDS

Date of Birth: Code A

Date:	Event:	Source:	Page(s):	Comments:
4/2/98	Assessed by D Code A *Severe dementia. Deteriorated since Christmas. Does not seem over-sedated, but spends significant part of the day asleep. At times quite agitated and distressed during the day. Mobile and able to wander. Try regular haloperidol.*	Correspondence	108	
		Correspondence Nursing home notes GP notes	90 677 773	
2/3/98	Reviewed by Code A *More settled. Conversation more coherent.*	Correspondence	106	

3/3/98	Reviewed by Code A (GP), and on 4/6/98, 9/7/98 and 23/7/98. *Pain in back from fall. No apparent injuries. Paracetamol to be taken PRN.*	Clinical notes	550	
		Nursing home notes GP notes	677 773-777	
29/7/98	Taken to A&E, Royal Hospital Haslar, after fall in nursing home, fracturing right neck of femur. *Fall onto right hip. Pain on movement of right leg. For admission, operation, PRN analgesia.*	Clinical notes	168 172	
30/7/98	Admitted from A&E, Royal Hospital Haslar. Undergoes operation – right hip hemi-arthroplasty.	Referral letter Significant events Clinical notes Operation record Drug charts Nursing notes Care plan	22 36 174 176 238-243 245 258	

31/7/98	Reviewed on ward round. *Up and eating. X-ray. Back to nursing home next week.*	Clinical notes	175	
		Nursing notes	244	
2/8/98	Reviewed by SHO.	Clinical notes	175	
3/8/98	Geriatric referral made. *All well on ward round. Sitting out. Has nursing home place but family not happy for her to return.* → *GWMH. Geriatric referral made.*	Clinical notes Nursing notes	184 280	

	Reviewed by Dr Reid. *Confused, but pleasant and cooperative. Able to move left leg freely. A little discomfort on passive movement of right hip. Sitting out in chair. Should be given opportunity to try to re-mobilise. Will arrange transfer to GWMH.*	Correspondence Clinical notes	24 185	
8/8/98	Reviewed by HO.	Clinical notes	185-186	
	Quite distressed first thing, but settled after haloperidol. Little breakfast taken, but ate well at lunchtime.	Nursing notes	296	
10/8/98	Referred to GWMH. *Needs total care with washing and dressing, eating and drinking. Soft diet. Enjoys a cup of tea. Continent. When becomes fidgety and agitated means she wants toilet. Occasionally incontinent at night. Occasionally says recognisable words. Wound healed, clean and dry. Pressure areas all intact.*	Referral letter	22/188	

11/8/98	Transferred to Daedalus Ward, GWMH. Reviewed by Dr Barton. *O/E frail demented lady. Not obviously in pain. Transfers with hoist. Usually continent. Needs help with ADL. Barthel 2. Happy for nursing staff to confirm death.*	Clinical notes	30	
		Significant events Assessment notes	36 38-43	

	Drug charts indicate: • Oramorph: Dr Barton prescribes 2.5-5ml (5-10mg) PRN. 10mg administered at 14.15 and 11.45 (possibly pm). • Diamorphine: Dr Barton prescribes 20-200mg/24hrs PRN by subcutaneous infusion. Not administered. • Hyoscine: Dr Barton prescribes 200-800µg/24hrs PRN by subcutaneous infusion. • Midazolam: Dr Barton prescribes 20-80mg/24hrs PRN by subcutaneous infusion. • Haloperidol: Dr Barton prescribes 1mg twice daily. One dose administered. • Lactulose: Dr Barton prescribes 10ml twice daily. Administered until 14/8/98 and on 17/8/98.	Drug charts	63-67	
12/8/98	Reviewed by nursing team *Requires assistance to settle and sleep at night. Nursing action: Night sedation if required. Observe for pain. 23.30: Haloperidol given as woke from sleep very agitated. Did not seem to be in pain.*	Nursing care plan	50	

	Drug charts indicate: • Oramorph: 10mg administered at 06.15. Dr Barton also prescribes 5mg four times daily and 10mg nocte PRN (in regular prescriptions section, marked "PRN"). These prescriptions not administered. • Haloperidol: Two 1mg doses administered.	Drug charts	63-67	
13/8/98	Found on floor at 13.30. *Beed: Found on floor at 13.30. No injury apparent on checking. Hoisted into safer chair. Pain right hip. Dr Brigg contacted. Advised x-ray and analgesia.*	Contact record	46	
		Nursing care plan	51	

	Drug charts indicate: • Oramorph: 10mg administered at 20.50. • Haloperidol: Two 1mg doses administered. Dr Barton also prescribes 0.5ml/1mg PRN "if noisy" (in regular prescriptions section, crossed out with "PRN" written in). One dose administered.	Drug charts	63-67	
14/8/98	Reviewed by Dr Barton. *Sedation/pain relief a problem. Screaming not controlled by haloperidol but very sensitive to oramorph. Fell out of chair. Right hip shortened. X-ray. Is this lady well enough for another surgical procedure?* *Later note: Appears to have dislocated right hip. Referred for relocation.*	Clinical notes	30-31	
	Hip x-ray. *Right hemiarthroplasty dislocated.*	X-ray report	78	

	Hip x-ray – disclocated. Daughter seen by Dr Barton. Informed of situation. For transfer to Haslar A&E for reduction and sedation.	Contact record	46	
	Letter from Philip Beed to Haslar A&E. *For reduction of disclocated R hip. No change in treatment since transfer to us 11/8/98 except addition or oramorph PRN. 10mg oramorph given at 11.50. Happy to take her back following reduction of dislocation.*	Correspondence	23	
	Re-admitted to Royal Hospital Haslar, for relocation of right hip. *Underwent closed relocation of right hip hemiarthroplasty under IV sedation. Catheterised. Given splint to discourage further dislocation. Can however mobilise, fully weight-bearing.*	Transfer letter	8	

		Contact record Nursing care plan A&E notes Clinical notes Operation notes Drug charts (Haslar) Nursing notes (Haslar)	46 51 194 196 202 286-291 297	
	Drug charts indicate (GWMH): • Oramorph: 10mg administered at 11.50. • Haloperidol: One 1mg dose administered.	Drug charts (GWMH)	63-67	
17/8/98	Transferred back to Daedalus Ward, GWMH.	Transfer letter	8	
	Reviewed by Dr Barton. *Readmission to Daedalus from RHH. Closed reduction under iv sedation. Remained unresponsive for some hours. Now appears peaceful. Plan: Continue haloperidol. Only give oramorph if in severe pain. See daughter again.*	Clinical notes	31	

	Joice: Patient very distressed, appears to be in pain. No canvas under patient – transferred on sheet by crew. To remain in straight knee splint.	Contact record	46-47	
	Hip x-ray. *Right hemiarthroplasty is relocated.*	X-ray report	76	
	Drug charts indicate: • Oramorph: 5mg administered three times during the day and 10mg administered at 20.30. • Diamorphine: Dr Barton prescribes 40-200mg/24hrs by subcutaneous infusion. • Haloperidol: One 1mg dose administered. Dr Barton also prescribes 5-10mg/24hrs by subcutaneous infusion.	Drug charts	63-67	

		Nursing care plan Clinical notes Discharge record Nursing notes (Haslar)	51 197 208 294	
18/8/98	Reviewed by Dr Barton. *Still in great pain. Nursing a problem. Will give SC diamorphine/haloperidol/midazolam. Will see daughters today. Please make comfortable.*	Clinical notes	31	
	7am: Reviewed by Dr Barton. For pain control on syringe driver. *Later: Treatment discussed with both daughters. They agree to use of syringe driver to control pain and allow nursing care to be given.*	Contact record	47-48	
		Nursing care plan	51	

	Drug charts indicate: • Oramorph: 10mg administered twice in early hours. • Diamorphine: 40mg/24hrs administered at 11.45. • Midazolam: 20mg/24hrs administered at 11.45. • Haloperidol: 5mg/24hrs administered at 11.45.	Drug charts	63-67	
19/8/98	Drug charts indicate: • Diamorphine: 40mg/24hrs administered at 11.20. • Midazolam: 20mg/24hrs administered at 11.20. • Haloperidol: 5mg/24hrs administered at 11.20. • Hyoscine: 200µg/24hrs administered at 11.20 (writing unclear – possibly 400µg).	Drug charts	63-67	
	AM: Mrs Richards comfortable. Daughter seen. Unhappy with various aspects of care.	Contact record	48	
		Nursing care plan	51, 59	

20/8/98	Drug charts indicate: • Diamorphine: 40mg/24hrs administered at 10.45. • Midazolam: 20mg/24hrs administered at 10.45. • Haloperidol: 5mg/24hrs administered at 10.45. • Hyoscine: 400µg/24hrs administered at 10.45.	Drug charts	63-67	
21/8/98	Reviewed by Dr Barton. *Much more peaceful. Needs hyoscine for rattly chest.*	Clinical notes	31	
	Joice: Patient's overall condition deteriorating. Medication keeping her comfortable.	Contact record	48-49	
	Drug charts indicate: • Diamorphine: 40mg/24hrs administered at 11.55. • Midazolam: 20mg/24hrs administered at 11.55. • Haloperidol: 5mg/24hrs administered at 11.55. • Hyoscine: 400µg/24hrs administered at 11.55.	Drug charts	63-67	

	Death recorded at 21.20.	Clinical notes Contact record	31 48-49	

2000/2947/03

Mr M E Usan

v

Dr Bacon

Memorandum

Ref: 2000/2047
To: Code A

Out	Back

From: Code A
020 7915 3617
Copy:

Date: 1 July 2002

Dr Jane Barton

I should be grateful for your view o Code A s's recommendation in this case. Please read in connection with the comments on file 2002/0553 (attached) – Code A s not currently taking any cases.

Please refer to my memos of 5 and 20 June 2002 and Dr Lewis's subsequent written comments (below) for the background to this case.

Should you require clarification on any of the matters raised, please do not hesitate to contact me.

Code A

I have considered the papers and in particular your memos and the course of action taken in the Reeves case. In light of this I agree with you + the medical screener's decision.

Code A

4/7/02

Consistency

A decision has already been taken to refer the deaths of patients Richards, Cunningham, Wilkie, Wilson and Page to the PPC and we are waiting to list these. These cases were reviewed by police medical expert's and are supported by reports critical of Dr Barton.

In addition to the 'police' cases we received complaints from Mr Wilson and Mrs Reeves. Dr Lewis screened Mrs Reeves case in May and recommended closure which was supported by the lay screener. Dr Lewis's reasons for this decision are given in his notes at Flag G*. On the face of it the issues raised by the Wilson and Reeves cases are very similar. Mrs Reeves has already been informed that her case is now closed.

Summary

To summarise therefore I do not feel that we necessarily have sufficient information on which to draft specific charges against Dr Barton, nor indeed any realistic prospect of obtaining any. Also I feel that we could have difficulty justifying a decision to proceed on Mr Wilson's complaint when have closed the apparently similar 'Reeves' complaint.

I should be grateful for the screener's views on the following options:

1. We pursue the Barton case solely on those matters referred by the police (and close the Wilson case)

2. We proceed with Wilson and review the closure decision on Reeves

3. We proceed as previously recommended.

A draft closure letter to Code A may be found at the back of the file should the screener be minded to reverse his original decision.

Code A

* I also attach the Reeves complaint file for the screener's consideration.

Dear **Code A**

Thank you for your file review. We may be at a stage where pursuing this case will not only be difficult in substance, but could detract from the strength of the other cases. I also would like discussion with the doctors / lack of record etc. with them in

Memorandum

Ref: 2000/2047
To: Gerry Leighton
Dr Lewis

Out	Back

From: Code A

Date: 5 June 2002

Dr Jane Ann BARTON Code A **BM BCH 1972 Oxfd**

Identification and previous history

Positively identified. 5 cases already referred to PPC.

Background

Dr Lewis will recall the case of Dr Jane Barton, the clinical assistant in elderly medicine at Gosport War Memorial Hospital (GWMH) who has been referred to PPC following information received from the police investigation about her management of, and prescribing to, a number of patients who died 'shortly' after being admitted to her care.

Mr Wilson wrote to the GMC about his mother's case (Edna Purnell) following the decision by Hampshire Constabulary not to bring any criminal charges against Dr Barton. Mrs Purnell's death was not one of the 5 cases reviewed by the police expert witnesses.

On 11 November 1998 Mrs Purnell was transferred to Dryad Ward at GWMH for 'gentle rehabilitation' following an operation on her broken hip at the Royal Haslar Hospital. Code A h maintains that his mother had made steady recovery whilst at the Haslar but suffered a marked deterioration once admitted to GWMH. Mr Wilson attributes this to substandard medical and nursing care and excessive prescribing of opiate and sedative drugs.
Mrs Purnell died on 3 December 1998

The following information is flagged:

Flag A – Mr Wilson's letter of complaint to GMC (14/02/02)

Flag B – Initial response from Trust

Flag C – Opinion of independent clinician

Flag D – Ombudsman's report

Flag E – Mr Wilson's comments on Ombudsman's findings

Discussion

At present we have 5 cases against Code A which are currently awaiting PPC listing. These were the only 5 deaths on which the police actively focused during

their investigation. A further complaint, not investigated by the police, was sent to the GMC but screened out. The screener will need to consider whether Code A 's complaint should be added to those cases previously referred.

I appreciate however that this latest complaint presents something of a dilemma.

First, there is the question of probative evidence. A section of Mrs Purnell's medical records appear to have been destroyed when sent for microfilming. Their contents are referred to in the Ombudsman's report although members of the medical and nursing staff are referred to as 'a doctor' or 'a nurse' rather than by name. Although Mr Wilson appears to be specifically complaining about Dr Barton it is difficult to adequately assess her role/actions on the basis of the information currently in our possession.

On the one hand it must be acknowledged that Mr Wilson's complaint has already been considered locally when it was accepted that Mrs Purnell's treatment was appropriate in the circumstances. This finding was reviewed and upheld by the Ombudsman. We have on file the views of a (disputed) independent expert and the Ombudsman's medical advisor although none which was commissioned by the police. If the screener is minded to accept in full the findings of the Trust/Ombudsman then the case would perhaps have to be closed (with lay agreement).

On the other hand, the issues raised by the complainant do appear similar to those later identified by the police expert witnesses in cases which have already been forwarded to PPC. The screener may therefore consider that on this basis alone there is a potential conflict of evidence and that this case should also proceed to PPC.

A third option would be to consider seeking an expert opinion of our own before making any decision. However, this may prove difficult given the absence of medical notes would of course involve extra delay.

I should be grateful for the screener's view on how best to proceed and attach a form SDF5 (opposite) for your possible use. Should you wish to discuss the matter further, please do not hesitate to contact me.

Code A

Medical Screener -

The other cases against Dr. Barton have proceeded on the basis of very helpful independent expert witness reports. This may be difficult to do here as medical evidence refutes those.

PPC will have difficulty if we have many here on hold. I think we should go forward on [illegible] SDF5, with your expert report.

Code A

7/6/02

Screening decision form
Section 1
Consideration by the Registrar: to determine whether enquiry is a complaint

GENERAL MEDICAL COUNCIL
Protecting patients, guiding doctors

Completed by the Office

FPD enquiry reference **Code A**

Date 21/02/12 (D D M M Y Y)

Dr's name† BARTON

1.1 Is the enquiry about a doctor?

Yes ☐ → *Q1.2*
No ☐ → *Q1.9a*

1.2 Has the doctor been charged or convicted?

Yes ☐ → *Q1.3*
No ☐ → *Q1.4*

1.3 Is the offence a minor motoring offence **not** involving drugs or alcohol?

→ *Q1.9a*
→ *Section 3*

1.4 Is the enquiry **or** ... Please open as complaint "OZ" on Case 2000/2047 - Dr Barton.

If multiple optio...

a. Concerning f...
b. Delay of less ...
c. The doctor's p... between neigh...
d. Objections to th... is no suggestion
e. Irrational / incohe...
f. Patently frivolous/... minutes late for a ...
g. Doctor failed to take ... but gave two weeks ...
h. A complaint from a t... does not want to pur...
i. A doctor's immigratio...
j. The level or quality of ... where there is no sugg...
k. Removal from a GP list ... decision was unfair or co...
l. Practice or Departmental ... patients are being put at ri...
m. Failures in local complaints
n. Correspondence is a copy le... GMC action

...ticks ...o to

Thanks

Code A

21/2

o. The correspondent is explicitly seeking only an apology ☐

p. Anonymous complaint where there is no reason to suspect that the doctor is an immediate threat to patients ☐

If any ticks here go to Q.1.9a

No, none of these ☐ → *Q.1.5*

1.5 Is the enquiry from a person acting in a public capacity (or on their behalf)?

Yes ☐ → *Section 2*
No ☐ → *Q1.6*

1.6 Is the enquiry about any of the following?
If multiple options apply tick the box for the main option

a. a doctor working in the NHS ☐
b. access to health records ☐
c. [In England, Wales or Northern Ireland] compulsory admission under the Mental Health Act and/or treatment received thereafter ☐
d. [In Scotland] care or treatment given to those suffering from a mental disorder ☐

If any ticks here go to Q1.7

e. none of these ☐ → *Q1.8*

1.7 Is there any reason to believe that the enquirer has already referred this matter to the appropriate complaints' handling body and exhausted that body's procedures before writing to the GMC?

Yes ☐ → *Q1.8*
No ☐ → *Q1.9*

1.8 *[NOTE: before the caseworker proceeds to seek consent etc. from the enquirer, where necessary, under the following section, he or she should consider whether this case should be referred to screeners under the initial screening procedures for treatment-related cases using SDF section B]*

Is the enquirer willing to:

a. Identify the doctor(s)?
Yes ☐ → *Q1.8b*
No ☐ → *Q1.9a*

b. Allow the GMC to disclose this to the doctor(s)?
Yes ☐ → *Q1.8c*
No ☐ → *Q1.9a*

c. Make a sworn statement?
Yes ☐ → *Section 2*
No ☐ → *Q1.9a*

*If any answers are **unknown**, request further information from the enquirer before completing this section and progressing to Section 2. This can include requesting information for medical screening.*

1.9a Is there any other reason why the enquiry should be seen by the Medical Screener?

Yes ☐ → *Q1.9b*
No ☐ → *Q1.10*

1.9b Please say why briefly (or append separate note)

.....

.....

.....

.....

Section 2

1.10 Declaration and certificate to close enquiry

Completed by Caseworker

I certify that I have processed this case in accordance with the instructions approved by the Screeners and that the information on this form matches that on the FPD system.

Signature ..... Date .....

Name .....

Completed by Casework Manager

I have examined this case. I certify that in my opinion there are no grounds to seek information about the doctor's fitness to practise from a source other than the complainant. I am satisfied that this case may be closed.

Signature ..... Date .....

Name .....

Screening decision form
Section 1
Consideration by the Registrar: to determine whether enquiry is a complaint

GENERAL MEDICAL COUNCIL
Protecting patients, guiding doctors

Completed by the Office

FPD enquiry reference **Code A**

Date 21/02/02 (D D M M Y Y)

Dr's name† ..... **Code A** .....

1.1 Is the enquiry about a doctor?

Yes ☐ → *Q1.2*
No ☐ → *Q1.9a*

1.2 Has the doctor been charged or convicted?

Yes ☐ → *Q1.3*
No ☐ → *Q1.4*

1.3 Is the offence a minor motoring offence **not** involving drugs or alcohol?

Yes ☐ → *Q1.9a*
No ☐ → *Section 3*

1.4 Is the enquiry **only** about the following?

If multiple options apply, only tick the box for the main option

a. Concerning fees charged for private treatment/service ☐
b. Delay of less than six months in providing a single medical report ☐
c. The doctor's profession is incidental to the matter, e.g. a dispute between neighbours, one of whom happens to be a doctor ☐
d. Objections to the contents of medical reports or records where there is no suggestion that the doctor acted unreasonably ☐
e. Irrational / incoherent enquiry ☐
f. Patently frivolous/trivial non-clinical matters, e.g. doctor a few minutes late for a routine appointment ☐
g. Doctor failed to take up a post following a verbal agreement to do so, but gave two weeks' notice or more ☐
h. A complaint from a third party where it is clear that the principal party does not want to pursue the matter, and no other reason for proceeding ☐
i. A doctor's immigration status ☐
j. The level or quality of service provided by a healthcare organisation where there is no suggestion that the doctor is directly responsible ☐
k. Removal from a GP list where there is no suggestion that the doctor's decision was unfair or contravened GMC guidelines ☐
l. Practice or Departmental disputes where there is no suggestion that patients are being put at risk ☐
m. Failures in local complaints handling procedures ☐
n. Correspondence is a copy letter which does not specifically request GMC action ☐

If any ticks here go to Q1.9a

Screening decision form
Section 4
Assessing Risk and IOC referral

GENERAL MEDICAL COUNCIL
Protecting patients, guiding doctors

FPD complaint reference **Code A** ☐ Date 12/02/02 (D D M M Y Y)

Dr's name BARTON Reg no **Code A** Complainant ☐☐☐☐☐

Q4.1 Regardless of the state of the information received so far, in your opinion does the doctor appear to be:

Tick all that apply

a. A current or imminent risk to the public or patients? Yes ☑ →Q4.2

b. At risk ifs/he continues to practise unrestricted? Yes ☑ →Q4.2
and/or

c. Does it appear to be contrary to the public interest for the doctor to continue practising unrestricted while the current issues are investigated? Yes ☐ →Q4.2

None of the above ☐ →*Sign and date. Return to the office*

Q4.2 What is the risk?

Tick only the main option
Evidence that doctor:

- Is suffering from a communicable disease ☐
- Appears to have been misled by a patient into acting against the patient's best interest (e.g. prescribing substantial amounts of controlled drugs) ☐
- Is being investigated or has been convicted of a serious criminal offence and public confidence in the profession will be seriously damaged if s/he continues to practise ☐
- Appears to have a level of skill/knowledge seriously below that expected and such that s/he poses a potential risk to patients ☐
- Appears to have caused serious harm to a patient(s) and may repeat this ☑
- Other, please specify ☐

→Q4.3

.....

.....

Q4.3 Should the IOC be asked to consider making an interim order?

Yes ☑ →Q4.4

No ☐ →Please give brief reasons. Sign & date and return to the office

Please specify reasons .....

.....

Screening decision form
Section 5
SPM or SDP

Completed by the Office (categorise) and the Medical Screener (judgement)

FPD complaint reference: **Code A** Date: 12/02/02 (D D M M Y Y)

Dr's name: Barton Reg no: **Code A** Complainant:

Q5.5 MUST BE COMPLETED BY THE MEDICAL SCREENER FOR ALL CASES UNLESS AN EARLIER REFERRAL TO IOC WAS AGREED

Q5.1 Did the events complained take place after 1 July 1997?

Yes ☐ *Could be spm or sdp*
No ☐ *Cannot be sdp may be spm* → Q5.2a
Combination ☐ *Could be spm or sdp*

Q5.2a Does the complaint fall into any of the following categories which raise an issue of spm?

SPM
Tick all that apply

	Office	Medical Screener	
Sexual assault or indecency			
Indecent behaviour	☐	☐	
Indecent assault	☐	☐	
Rape/attempted rape	☐	☐	
Female circumcision	☐	☐	
Violence			
Assault/breach of the peace	☐	☐	
Attempted murder	☐	☐	
Firearms offences	☐	☐	
Murder/manslaughter	☐	☐	
Robbery	☐	☐	
Dysfunctional conduct			→ Q5.5
Improper sexual/emotional relationship	☐	☐	
Offences under the Abortion Act	☐	☐	
Persisting in practice when carrier of an infectious disease	☐	☐	
Controlled substance offences	☐	☐	
Dishonesty			
False claims to qualifications/experience	☐	☐	
Financial fraud/deception	☐	☐	
Forgery/improper alteration of documents	☐	☐	
Research misconduct	☐	☐	
Theft	☐	☐	
None of the above apply	☐	☐	→ Q5.2b

Q5.2b The following categories might raise an issue of spm and/or suggest there may have been sdp.

Office: Tick all categories that apply
Medical Screener: Please make a judgement for each category ticked by the office,
And any others that you judge appropriate.

- SPM is action or inaction by a doctor of a serious kind of which no doctor of reasonable skill and exercising reasonable care would be responsible. The weight of the evidence and the intent of the doctor should not be taken into account when reaching a decision on whether a question of SPM is raised at this stage
- SDP is normally indicated by a pattern of serious failure to comply with relevant professional Standards. When deciding whether a complaint raises an issue of sdp, evidence before 1 July 1997 cannot be taken into account.

Tick all that apply

	Office	Medical Screener	
Dysfunctional conduct			
Abusive behaviour	☐	☐	
Driving under the influence of alcohol/drugs	☐	☐	
Failure to report dysfunctional colleague(s)	☐	☐	
Soliciting money from patients	☐	☐	
Dishonesty			
False certifications/false reporting	☐	☐	
False claims about effectiveness of treatment	☐	☐	
Sub-standard clinical practice and care			
Communication skills	☐	☐	
Confidentiality issues	☐	☐	
Consent issues	☐	☐	
Inadequate practice arrangements	☐	☐	
Inappropriate/irresponsible prescribing	☐	☑	
Practising beyond limits of skills or knowledge	☐	☐	→Q5.2c
Relations with colleagues	☐	☐	
Relations with patients	☐	☐	
Sub-standard treatment	☐	☑	
Other complaints and enquiries			
Administration of nursing/residential homes	☐	☐	
Advertising	☐	☐	
Canvassing of patients/other practice disputes	☐	☐	
Medical reports/records issues	☐	☐	
Removal from practice list	☐	☐	
Treatment under the Mental Health Act	☐	☐	
Other *(please specify)*	☐	☐	
.....			
.....			
.....			
None of the above apply	☐	☐	→ Q5.2c

To be completed by the Medical Screener

Q5.2c The following criteria may assist in assessing whether the conduct or performance procedures are appropriate. This list is not exhaustive but may be an indicator of sdp.

Tick all that apply

A doctor who has a tendency to use inappropriate techniques	☐	Q5.3
A lack of basic knowledge/poor judgement	☐	
A lack of familiarity with basic clinical/administrative procedures	☐	
A doctor who has failed to keep up to date records	☐	
A lack of insight	☐	

A range of inadequacies:		
Outdated techniques	☐	Q5.3
Attitude	☐	
Inadequate practice arrangements	☐	
Concerns over referral rates	☐	
Poor record keeping	☐	
Inadequate hygiene arrangements	☐	
Other (*please specify)*	☐	

Q.5.3 On the basis of information, in your opinion does the case raise an issue of spm or is there a suggestion there may have been sdp?

spm	☑ Refer to next PPC	→Q5.5
sdp	☐ Send performance Rule 5 letter	→Q5.5
both	☐	→Q5.5
cannot judge	☐	→Q5.4

Please give brief reasons for your decision Evidence of repeated practice problem that is described as inappropriate by colleagues

To be completed by the Medical Screener

Q5.4 If you cannot make a decision on the information currently available, from whom is further information required and **what** is required?

Tick all that apply		*Write a brief note*	
Complainant	☐	.....	→ *Q5.5 then Sign, date and return to the office (to seek further information)*
HA/NHS Trust/PCT	☐	.....	
GMC' solicitor's investigation	☐	.....	
Other (please specify)		.....	
.....	☐	.....	
.....	☐	.....	

Signed (Medical Screener) .....

Date .....

Q5.5 Regardless of the state of the information, in your opinion does there appear to be a current or imminent risk to the public?

Yes ☑ → *Q5.6 and SDF 4*
No ☐ → *Q5.6*
Already referred. N/A ☐ → *Q5.6*

Q5.6 Based on the information available to you at this stage, please rate the seriousness of the doctor's alleged behaviour/conduct.

Tick one option only

a. Very serious ☑
b. Quite serious ☐
c. Not very serious ☐
d. Not at all serious ☐

→ *Q5.7*

Q5.7 Do any of the following exceptions apply?

If multiple options apply, only tick the box for the main option

a. Doctor is terminally ill and not in active practice ☐
b. There is no tenable basis for taking action because:
   i. The complainant has declined reasonable requests for further information ☐
   ii. There is no probative evidence to support the allegation(s) nor any prospect of obtaining any ☐
   iii. The complaint is self-evidently untrue/irrational ☐
c. None of the above apply ☑

→ *Q5.8*

Declaration

Q5.8a In my view this case raises:

Tick one box only

a. An issue(s) of spm and should be referred to the next available PPC ☑ 10 C.
b. An issue(s) of sdp and a performance Rule 5 letter should be sent ☐

→ *Sign, date below and return to the office*

c. Issues of both spm and sdp ☐ → *Q5.8b*
d. No issues of spm or sdp ☐ → *Q5.8c*

Q5.8b In my opinion this case should be considered in accordance with:

Tick one box only

a. The conduct procedures ☑ → Refer to next PPC fitness to practise
b. The performance procedures ☐ → Performance R5 letter

Signed (Medical Screener)

Date

Code A

OR

Q5.8c In my view this case cannot proceed under either the conduct or performance procedures for the reasons as shown at Q5.7 ❑ *Sign, date and return to the office*

Signed (Medical Screener) .....

Date .....

To be completed by the Lay Screener

Q5.9a Do you agree with the Medical Screener's decision at Q5.8?

Yes ❑ → *Sign, date and return to the office*

No ❑ → Q5.9b

Signed (Lay Screener) .....

Date .....

Q5.9b Please state briefly why you do not agree with the Medical Screener's decision at Q5.8

.....

.....

.....

.....

..... } *Sign, date and return to the office*

Signed (Lay Screener) .....

Date .....

2000/2047

HAMPSHIRE Constabulary

Paul R. Kernaghan QPM LL.B MA DPM MIPD
Chief Constable

Major Incident Complex
Police Station
Kingston Crescent
Portsmouth
Hampshire
PO2 8BU

Our Ref. HQ/CID/SE/DCI/2000

Your Ref.

Tel. Extn: Code A
Fax.

27/07/00

The Fitness to Practice Directorate
General Medical Council,
178 Great Portland Street,
London,
WIN 6JE.
For the attention of Code A

Private and Confidential

Dear Code A

Re: Dr. Jane BARTON G.P.

Further to my telephone call of yesterday's date, I wish to provide brief details of an investigation which is currently being conducted by the Hampshire Constabulary.

An allegation has been made by members of the family of a woman named Gladys RICHARDS to the effect that she was unlawfully killed as a result of treatment received at the Gosport War Memorial Hospital (GWMH) during or about the period 17th-21st August 1998. The doctor who appears to have been responsible for the care of Mrs RICHARDS at the time is Dr. Jane BARTON (born: Code A who is a General Practitioner practising in Gosport, Hampshire. ~~Dr. BARTON is~~ additionally engaged by the Portsmouth Healthcare (NHS) Trust as a visiting Clinical Assistant at the GWMH. Dr. BARTON currently practises at The Surgery, 148 Forton Road, Gosport, Hampshire. The investigation is ongoing and no criminal charges have been preferred. Dr. BARTON is represented by Code A of HEMSONS (Solicitors) of London.

If you require any further information, please do not hesitate to contact me.

Yours sincerely,

Code A

R. J. BURT
Acting Detective Superintendent

2000/2047

HAMPSHIRE Constabulary

Paul R. Kernaghan QPM LL.B MA DPM MIPD
Chief Constable

Major Incident Complex
Police Station
Kingston Crescent
Portsmouth
Hampshire
PO2 8BU

Our Ref. HQ/CID/SE/DCI/2000

Your Ref.

Tel. Code A
Extn:
Fax.

27/07/00

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General Medical Council,
178 Great Portland Street,
London,
WIN 6JE.
For the attention of Code A

Private and Confidential

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If you require any further information, please do not hesitate to contact me.

Yours sincerely,

Code A

R. J. BURT
Acting Detective Superintendent

2000/2047

HAMPSHIRE Constabulary

Paul R. Kernaghan QPM LL.B MA DPM MIPD
Chief Constable

Major Incident Complex
Police Station
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Our Ref. HQ/CID/SE/DCI/2000

Your Ref.

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Fax.

27/07/00

The Fitness to Practice Directorate
General Medical Council,
178 Great Portland Street,
London,
WIN 6JE.
For the attention of Code A

Private and Confidential

Dear Code A

Re: Dr. Jane BARTON G.P.

Further to my telephone call of yesterday's date, I wish to provide brief details of an investigation which is currently being conducted by the Hampshire Constabulary.

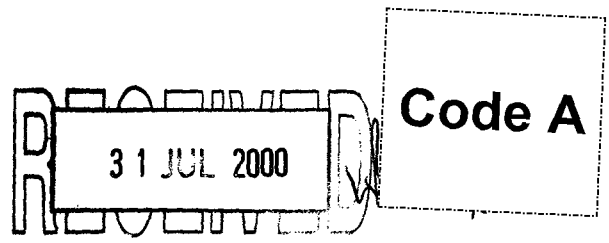
An allegation has been made by members of the family of a woman named Gladys RICHARDS to the effect that she was unlawfully killed as a result of treatment received at the Gosport War Memorial Hospital (GWMH) during or about the period 17th-21st August 1998. The doctor who appears to have been responsible for the care of Mrs RICHARDS at the time is Dr. Jane BARTON Code A who is a General Practitioner practising in Gosport, Hampshire. Dr. BARTON is additionally engaged by the Portsmouth Healthcare (NHS) Trust as a visiting Clinical Assistant at the GWMH. Dr. BARTON currently practises at The Surgery, 148 Forton Road, Gosport, Hampshire. The investigation is ongoing and no criminal charges have been preferred. Dr. BARTON is represented by Code A of HEMSONS (Solicitors) of London.

If you require any further information, please do not hesitate to contact me.

Yours sincerely,

Code A

R. J. BURT
Acting Detective Superintendent


31 JUL 2000
Code A

Your reference HQ/CID/SE/DCI/2000

In reply please quote WB/2000/2047

GENERAL MEDICAL COUNCIL

Protecting patients, guiding doctors

19 September 2000

R J Burt
Acting Detective Superintendent
Hampshire Constabulary
Major Incident Complex
Police Station
Kingston Crescent
Portsmouth
Hampshire PO2 8BU

Dear Acting Detective Superintendent Burt

Dr Jane Ann Barton

I write regarding your letter of 27 July 2000 notifying the GMC that Dr Barton was under investigation for alleged unlawful killing.

It would be most appreciated if you could update us on the current position of this case and in particular, the outcome of your enquiries. Also please confirm whether the doctor has been charged.

Thank you for your assistance in this matter.

Yours sincerely

Code A

Fitness to Practise
020 7915 3627
Fax 020 7915 3642

HAMPSHIRE Constabulary

Paul R. Kernaghan QPM LL.B MA DPM MCIPD
Chief Constable

Major Incident Complex
Police Station
Kingston Crescent
Portsmouth
Hampshire
PO2 8BU

Our Ref. HQ/CID/SE/DCI/2000

Your Ref.

Tel. Code A
Ext:
Fax.

18/09/00

Code A
The Fitness to Practice Directorate
General Medical Council
178 Great Portland Street
LONDON
W1N 6JE

IN CONFIDENCE

Dear Code A

Re: Dr Jane BARTON G.P.

Further to my previous letter of the 27th July 2000, may I please formally enquire as to whether the General Medical Council are aware of any complaints or allegations made against Dr BARTON which might bring into question professional competence or standards of care.

Yours sincerely,

Code A

R J BURT
Detective Chief Inspector

2000

22 SEP 2000

HAMPSHIRE Constabulary

Paul R. Kernaghan QPM LL.B MA DPM MCIPD
Chief Constable

Major Incident Complex
Police Station
Kingston Crescent
Portsmouth
Hampshire
PO2 8BU

Our Ref. HQ/CID/SE/DCI/2000

Your Ref.

Tel. Code A
Ext:
Fax.

20/09/00

Code A
Fitness to Practice Directorate
General Medical Council
178 Great Portland Street
LONDON
W1N 6JE

IN CONFIDENCE

Dear Code A

Re: Dr Jane BARTON G.P.

My letter of the 18/9/00, and yours of the 19/9/00, appear to have crossed in the post.

The investigation is ongoing and a file will be submitted to the Crown Prosecution Service as soon as possible. I would estimate that the outcome is unlikely to be known for at least 3 - 4 months.

Dr BARTON has not been charged with any criminal offence.

Yours sincerely,

Code A

R J BURT
Detective Chief Inspector

22 SEP 2000

VB 26/9/00

Your reference **HQ/CID/SE/DCI/2000**

In reply please quote **WB/2000/2047**

GENERAL MEDICAL COUNCIL

Protecting patients, guiding doctors

26 September 2000

R J Burt
Detective Chief Inspector
Hampshire Constabulary
Major Incident Complex
Police Station
Kingston Crescent
Portsmouth
Hampshire PO2 8BU

Dear Detective Chief Inspector Burt

Dr Jane Ann Barton

Thank you for your letters of 18 and 20 September 2000 respectively, the contents of which have been noted.

You wanted to know whether the GMC were aware of any complaints or allegations made against the above-mentioned doctor. I have checked our records and I can confirmed that there has been no complaints made against Dr Barton and she has not appeared before the Professional Conduct Committee.

We shall await your further correspondence in respect of the outcome of investigations relating to this matter.

Yours sincerely

Code A

Fitness to Practise
020 7915 3627
Fax 020 7915 3642

FITNESS TO PRACTISE DIRECTORATE

CONDUCT & REFERRALS

TELEPHONE MESSAGES

Call taken by: Code A

Date: 30 January 2001	Time: 10:28
Name of caller: DCI Burt of Hampshire Constabulary	Caller's status: (eg MP, patient's mother)
'Phone number of caller: Code A	Address of caller: (if necessary)
Doctor(s) complained/enquired about: Dr J A Barton	If we have file already open - file reference: 2000/2047

Summary of 'phone call:

1. DCI Burt returned my call.
2. The case was sent to the Crown Prosecution Service (CPS) about 2/3 weeks ago.
3. He does not expect to hear from the CPS for a least a month.
4. He will update us on the outcome in due course.

For next action by:

Code A

From: Code A
Sent: 16 March 2001 14:06
To: Code A
Subject: FPD/2000/2047 - Code A

DCI Burt called. The papers are with the CPS for advice and they, in turn , have referred the matter to Treasury Counsel for advice. He does not know how long it will be before he has an answer, but he assured me he will provide regular updates.

From personal experience the TC's usually turn their advices around quite quickly but the CPS branches then procrastinate as several "senior management" lawyers get involved in making the final decision. As this matter is being handled by a specialist unit you may be lucky and get a reply within the month.

Code A

Code A

Code A

Can Man make contact with the Trust PAs and obtain further details?

Code A 18/4

Code A 11/4

Can we find out about this please?

Code A 9/4

© DAILY TELEGRAPH
09/04/01

Police look into deaths of elderly at hospital

POLICE investigating an allegation that a 91-year-old woman was unlawfully killed at a hospital are examining the circumstances surrounding the deaths of three more patients.

Relatives of three pensioners came forward after police announced their inquiry into the woman's death.

Detectives have spent two years investigating the woman's death at the National Health Service War Memorial Hospital in Gosport, Hants.

A file has been sent to the Crown Prosecution Service and if the case goes to court the files into as many as 600 deaths of elderly people could be re-opened.

It is thought the three new inquiries will involve concerns over the use of the pain-killing drug diamorphene.

Detectives have interviewed a number of medical staff at the hospital, though there have been no arrests.

One of the relatives in the fresh investigations had protested to the health service ombudsman after his mother, Edna Purnell, 91, died in December 1998.

Her son, Mike Wilson, claimed his mother had fallen into a "trance-like" state before her death.

The ombudsman examined Mr Wilson's complaint against Portsmouth Health-Care NHS Trust but cleared the hospital of any blame.

The ombudsman concluded: "I have not found evidence of unsatisfactory medical or nursing care and am satisfied Mrs Purnell was not given excessive doses of morphine."

But the report criticised the hospital for the way in which some of her medical notes were destroyed.

"The early destruction of the records was contrary to the trust's own policy and went against official guidance," it said. "The trust expressed their deep regret ... and said it was the only time such an error had been made."

Detectives will also scrutinise events surrounding the death at the hospital last September of Jack Williamson, 81, of Gosport.

His son Ian, 48, said he thought it "rather strange" that his father had died days after his mother Ivy, 76.

A widow from Fareham, Hants, has also approached police about her husband's death at the hospital.

THE SUN
09/04/01

COPS PROBE 15 NHS DEATHS

DETECTIVES probing claims that a 91-year-old woman was unlawfully killed at an NHS hospital are investigating three more pensioners' deaths.

Relatives of the trio called cops after learning of their two-year inquiry at the War Memorial Hospital in Gosport, Hants.

A file on the 91-year-old has gone to Crown Prosecutors. If it goes to court, files may re-open into **600** patients' deaths.

It is thought the new inquiries will probe concerns over pain-killing drugs. Hospital chiefs pledged full co-operation.

THE TIMES
10/04/01

Code A

Police to examine hospital deaths

By Stewart Tendler
Crime Correspondent

POLICE investigating the death of a 91-year-old in a Hampshire hospital are interviewing the families of three other elderly patients who have died there.

A report on circumstances surrounding the death of the woman has been sent to the Crown Prosecution Service.

She died in 1998 in the War Memorial Hospital at Gosport and her family later made a complaint of unlawful killing. The dead woman has never been named.

Last month a detective inspector and a detective constable were criticised for their handling of the case after an internal inquiry supervised by the Police Complaints Authority. Last week relatives of Edna Purnell, also 91, came forward to police after news of the investigation was made public. Mrs Purnell died a few months after the other woman. The son of Jack Williamson, 81, and his wife, Ivy ,76, who died last September, has also complained.

Code A

As discussed Code A

MEDIA SERVICES

NEWS RELEASE

OPERATION ROCHESTER

Police have completed their investigation into the circumstances surrounding the death of a 91-year-old woman from Lee on Solent following a complaint by her family.

She died in August 1998 at the War Memorial Hospital in Gosport after being transferred there from Royal Hospital Haslar.

In line with patient confidentiality we cannot reveal the nature of her medical condition.

A file has have been sent to the Crown Prosecution Service and police are awaiting its decision.

We have the full co-operation of the Portsmouth HealthCare (NHS) Trust and the Royal Hospital Haslar for our investigation.

Ends Code A Code A

Hampshire Constabulary Media Services
Police Headquarters, Romsey Road,
Winchester SO22 5DB
T: 01962 871619 F: 01962 871194
mediaservices@hampshire.police.uk

Your reference: HQ/CID/SE/DCI/2000

In reply please quote: FPD/2000/2047

11 April 2001

First Class: Confidential

GENERAL MEDICAL COUNCIL

Protecting patients, guiding doctors

DCI Ray Burt
Hampshire Constabulary
Criminal Investigation Department
Police Headquarters
West Hill, Winchester
Hampshire SO22 5DB

Dear Detective Chief Inspector Burt

Dr Jane Ann BARTON (1587920)

Thank you for the details that you provided during our telephone conversation today.

As you will be aware, the GMC was granted additional powers by Parliament last summer which, in effect, allow us to consider restricting a doctor's registration status, *without prejudice*, at any stage of our proceedings if it is deemed to be in the public interest or the interests of the doctor concerned. All meetings of this new Interim Orders Committee are held in private. It appears that, given the nature of the allegations against Dr Barton, this case may fall into the above category.

Before considering whether an interim order is appropriate in this case we need to be in possession of sufficient information on which to make a fair judgement. To this end I should be grateful if you would furnish us, at your earliest convenience, with a brief case summary, copies of witness statements, transcripts of interviews conducted, copies of the medical expert's report and the relevant medical notes. Any information we consider under these new procedures would naturally be disclosed to the doctor beforehand to allow her to prepare a defence. We understand that Dr Barton has not been formally charged over these allegations and it would therefore be useful if, when disclosing information to us, you could provide an indication of which documents you would permit us to disclose to Dr Barton at this time and therefore use in connection with our proceedings.

We appreciate that when disclosing confidential information you need to balance the rights of privacy of the individual against a necessary need to protect the public. However, given both the nature of the allegations against Dr Barton and her public position, we feel our request for information is reasonable and relevant.

178 Great Portland Street London W1W 5JE Telephone 020 7580 7642 Fax 020 7915 3641
email gmc@gmc-uk.org www.gmc-uk.org

If you would find it helpful to meet to discuss these matters further, we would be happy to do so at your earliest convenience.

Thank you for your assistance. I look forward to hearing from you.

Yours sincerely

Code A

Your reference

In reply please quote **JS/2000/2047**

Please address your reply to Fitness to Practise Directorate
Fax Code A

20 April 2001

GENERAL MEDICAL COUNCIL
Protecting patients, guiding doctors

First class: Confidential

DCI Ray Burt
Hampshire Constabulary
Criminal Investigation Department
Police Headquarters
West Hill
Winchester
Hampshire SO22 5DB

Dear DCI Burt

Dr Jane Ann BARTON

I am writing further to recent correspondence and telephone conversations with my colleague, S Code A

I have now taken conduct of this matter and would appreciate it if you could contact me so that we can arrange a mutually convenient time to meet to discuss matters. We are happy to visit you, if this would be more convenient. I wonder whether the week commencing 30 April 2001 would be convenient to you?

I look forward to hearing from you.

Yours sincerely

Code A

178 Great Portland Street London W1W 5JE Telephone 020 7580 7642 Fax 020 7915 3641
email gmc@gmc-uk.org www.gmc-uk.org

HAMPSHIRE Constabulary

Paul R. Kernaghan QPM LL.B MA DPM MIPD
Chief Constable

Criminal Investigation Department
Police Headquarters
West Hill
Winchester
Hampshire
SO22 5DB

Our Ref. : HQ/CID/DCI 7410/2001

Your Ref. :

Tel. : Code A
Ext. :

23 April 2001

Code A
Fitness to Practice Directorate
General Medical Council
178 Great Portland Street
London
W1W 5JE

CONFIDENTIAL

Code A

Dr. Jane Ann Barton

I write with reference to our telephone conversation, today, and the letter that I received from your colleague Code A dated of the 11th April 2001.

I confirm that I have referred the matters raised to Mr. P. Close of the Casework Directorate, Crown Prosecution Service, 50 Ludgate Hill, London EC4M 7EX.

You advised me, today, that you have spoken to Mr Close and that he confirmed that he has sought counsel's opinion as regards the disclosure of information to yourselves.

I look forward to meeting you at Police Headquarters, Winchester on Wednesday 2nd May 2001 at 1200 hours.

Code A

R.J. Burt
Detective Chief Inspector

15/05 '01 TUE 14:25 FAX Code A GMC 001

****
*** TX REPORT ***
****

TRANSMISSION OK

TX/RX NO	1726
CONNECTION TEL	Code A
SUBADDRESS	
CONNECTION ID	
ST. TIME	15/05 14:24
USAGE T	01'06
PGS.	3
RESULT	OK

Fax

To DCI Ray Burt

Fax number 01962 - 871130

From Jackie Smith

Direct Dial 020 7344 3753

Direct fax 020 7915 3642

No. of pages (inclusive) 3 *Time* 14:20 *Date* 15 May 2001

GENERAL MEDICAL COUNCIL

Protecting patients, guiding doctors

Dear DCI Burt

Further to our telephone conversation earlier today, please find enclosed a copy of the letter sent to Code A

If you require any further information, please do not hesitate to contact me.

Kind regards.

Code A

178 Great Portland Street London W1W 6JE

Our ref: KET/GAH/3015

Private and Confidential

Code A
Hampshire Constabulary
Criminal Investigation Department
Police Headquarters
West Hill
Winchester
Hampshire SO22 5DB

4 May 2001

Dear Code A

General Medical Council - Dr Jane Barton

As you are aware, this firm is instructed by the General Medical Council, the regulatory body of the medical profession.

It was a pleasure to meet you and your police colleagues on Wednesday.

I write to formally request disclosure of the following material which I understand is in the possession of acting DS Burt:

1. Statements made by the daughters of Gladys Richards deceased;

2. Statement of Dr Jane Barton;

3. Medical records of Gladys Richards deceased;

The above information will be placed before the Interim Orders Committee of the General Medical Council as soon as possible so that they may decide whether to take any action to limit Dr Barton's registration with the General

Medical Council, in the interest of protecting the public and pending the outcome of the police enquiries. As I explained to DS Burt, all documents passed to us will be disclosed to Dr Barton. It would also greatly assist the Interim Orders Committee if DS Burt or one of his colleagues would be able to provide information, probably in the form of a letter, explaining that there is an investigating currently proceeding and that a file has been submitted to the CPS. The letter should indicate, if possible, the nature of the charge that may be brought against Dr Barton and when the CPS might be expected to make a decision as to whether the case will proceed.

I understand that the police have an expert report from Brian Livesley. However, I further understand that this has not yet been disclosed to Dr Barton and that disclosure to us at the present time may prejudice the police investigation. I therefore do not request disclosure of this expert report.

As you will appreciate, the GMC will wish to act promptly to bring this mater before the Interim Orders Committee in the interest of protecting the public and I would be very grateful to hear from you as a matter of urgency with the requested documentation. You have indicated that you are prepared to release the documents to us for which I am extremely grateful.

Yours sincerely

Code A

Direct Line: 020 7861 4909
Email: ket@ffwlaw.com

Solicitors to the General Medical Council

HAMPSHIRE Constabulary

Code A

West Hill, Winchester
Hampshire, SO22 5DB

Telephone:
Ext:
Facsimile: Code A
DX:

Your Ref:

Our Ref: D4/MNW/SB/misc.57/01

21 May 2001

Ms J Smith
General Medical Council
178 Great Portland Street
London
W1N 6JE

copy: DCI R Burt
Headquarters CID

Operation Rochester
Fratton Police Station

Dear Code A

GENERAL MEDICAL COUNCIL – DR JANE BARTON

I refer to your fax of 15 May enclosing a copy of a letter dated 4 May 2001 addressed to me. I can confirm that I had not seen the 4 May letter from Code A and that is the reason why a reply was not forthcoming.

We did meet in the Detective Chief Superintendent's office of this Headquarters and I would wish to stress that the Hampshire Constabulary will do all they can to assist the General Medical Council in reaching what will inevitably be a difficult decision. We are mindful of the Woolgar decision and have no difficulty releasing information to the GMC as a regulatory body concerned with health and safety.

However, we are keen to focus our attention on investigating any allegations of a criminal nature and we appreciate your understanding about the inappropriateness of perhaps disclosing something to the GMC which has not been made available to Dr Barton. There are clearly priorities when it comes to disclosure and it is better that information obtained by the police goes direct to Dr Barton rather than via the GMC.

With this in mind, we are going to release immediately the statements of the daughters of the late Code A the statement of Code A and the medical records of the late Code A Those will be sent to you from Fratton Police Station where the officers dealing with Operation Rochester are based. We fully appreciate that, if you are to use the information supplied, it must be disclosed to Code A Code A I can confirm that the documents you will receive are already in the doctor's possession having been disclosed to her by us.

I hope this deals with the various points you raise and, if we can be of any further assistance, please do not hesitate to contact us.

Yours sincerely

Code A

22 MAY 2001

Your reference D4/MNW/SB/misc.57/01
In reply please quote 2000/2047
Fax Code A

22 May 2001

Private and Confidential

GENERAL MEDICAL COUNCIL
Protecting patients, guiding doctors

Code A
Force Solicitor
Hampshire Constabulary
West Hill
Winchester
Hampshire
SO22 5DB

Dear Code A

Thank you for your letter of 21 May 2001. We look forward to hearing from Fratton Police Station .

Yours sincerely

Code A

178 Great Portland Street London W1W 5JE Telephone 020 7580 7642 Fax 020 7915 3641
email gmc@gmc-uk.org www.gmc-uk.org

FITNESS TO PRACTISE DIRECTORATE

CONDUCT & REFERRALS

TELEPHONE MESSAGES

Call taken by: Code A	
Date: 25/5/01	Time: 17:25
Name of caller: DCI Ray Burt	Caller's status: DCI @ Hants Constabulary
'Phone number of caller: Code A	Address of caller: See File (if necessary)
Doctor(s) complained/enquired about Code A	If we have file already open - file reference:

Summary of 'phone call:

1. DCI Burt called to inform us that the point of contact for this case is now the Force solicitor, Code A Additionally, the senior investigating officer is now DS John James, based at the same office as DI Sackman.
2. DCI Burt said that the police are anxious to assist re: the policy agreed in respect of the case of Dr Barton.
3. He will be writing to us regarding these matters.
4. However, he is more than willing to discuss this case on Tuesday 29 May if need be and may well phone you himself.

For next action by: Tuesday 29 May 2001

HAMPSHIRE Constabulary

Paul R. Kernaghan QPM LL.B MA DPM MIPD
Chief Constable

Criminal Investigation Department
Police Headquarters
West Hill
Winchester
Hampshire
SO22 5DB

Our Ref. : HQ/CID/DCI 7410/2001

Your Ref. :

Tel. : Code A
Extn. :

29th May 2001

Code A
Fitness to Practice Directorate
General Medical Council
178 Great Portland Street
LONDON
W1N 6JE

Dear Ja Code A

Re: Gladys Mable RICHARDS

I am writing to advise you that with effect from Monday 21st May 2001 the Senior Investigating Officer (SIO), in charge of the police enquiry into the circumstances of the death of Gladys Mable Richards at the War Memorial Hospital (Gosport) on the 21st August 1998 and any other alleged criminal matters that may stem from this investigation, became Detective Superintendent John James.

Detective Superintendent Code A based at the Major Incident Complex, Police Station, Kingston Crescent, Portsmouth, Hampshire PO2 8BU (telephone no. 0845 045 4545 ext. Code A Code A

Code A the Force Solicitor, will continue to be your point of contact so far as disclosure of information in connection with your internal processes is concerned

Thank you for the assistance given to me during my tenure as SIO.

Yours Sincerely,

Code A

Ray Burt
Detective Chief Inspector

HAMPSHIRE Constabulary

Paul R. Kernaghan QPM LL.B MA DPM MCIPD
Chief Constable

Fratton Police Station
Kingston Crescent
Portsmouth
North End
Portsmouth
PO2 8BU

Our Ref. : Op Rochester

Your Ref. :

Tel. :
Direct Dial : Code A
Fax. :

06 June 2001

Code A
General Medical Council
178 Great Portland Street
London
W1N 6JE

Dear Code A

GENERAL MEDICAL COUNCIL – DR JANE BARTON

I have been asked by DCI Ray BURT to provide you with the following documentation all previously disclosed to Dr BARTON.

1. Statement of Lesley LACK
2. Statement of Gillian MACKENZIE
3. Medical notes Gladys RICHARDS

Please accept my apologies for not supplying them earlier I have been on leave.

Yours Sincerely

Code A

53

MG11(T)

HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

Statement of : **Lesley Frances LACK**

Age if under 18 : **Over 18yrs** (if over 18 insert 'over 18')

Occupation : **Retired**

This statement (consisting of 20 pages each signed by me) is true to the best of my knowledge and belief and I make it knowing that, if it is tendered in evidence, I shall be liable to prosecution if I have wilfully stated in it anything which I know to be false or do not believe to be true.

Signature : Code A **Dated the** 31. January 2000

I am the natural daughter of Gladys Mable RICHARDS (Nee BEECH) who was born on the Code A Code A

My mother died on the 21st August 1998 whilst she was an admitted patient at the Gosport War Memorial Hospital.

I am a retired Registered General Nurse (RGN). I retired during 1996 after 41 years, continuously, in the nursing profession. For 25 years, prior to my retirement, I was involved in the care of elderly people. For 20 years, prior to my retirement, I held supervisory and managerial positions in this particular field of nursing.

My mother was a resident in two nursing homes from I991 or thereabouts. The first was located in the Basingstoke area and the most recent was the 'Glen Heathers' Nursing and Residential Home, Milvil Road, Lee on Solent, Hampshire. My mother spent approximately four years at the Glen Heathers' Home. On admission to Glen Heathers my mother was ambulant - able to go up and down stairs and walk well.

She was generally well, physically, but had the onset of dementia and became increasingly forgetful. At the beginning of 1998 my mother's dementia was becoming more marked and she had become less able physically. She was inclined to wander and following a change in her medication began to have falls.

However, despite this my mother was able to stand, walk and attend the toilet. I used to take her out for trips in my car. Her last visit to my home occurred during Christmas 1997.

My mother left the 'Glen Heathers' Home on the 29th July 1998 and was admitted to the Haslar Hospital, Gosport.

Code A

Signed : L. F. LACK

Signature witnessed by : Code A

MG11A(T)(cont.)

HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

Continuation of Statement of : **Lesley Frances LACK**

My mother had suffered a fall, at the Home, at approximately 1450 hours during the afternoon of that day. She was eventually taken to Haslar Hospital, by ambulance, at approximately 2100 hours that evening where she was diagnosed as having broken a neck of femur on her right side.

Whilst it may not have a direct bearing on my main concerns surrounding my mother's death, which I will describe later in this statement, I would like to point out that I did have serious reservations as regards the standard of care which my mother was receiving whilst residing at the 'Glen Heathers' Home.

In fact, following my mother's admission to the Haslar Hospital on the 29th July 1998, I had decided that, if and when my mother recovered, she would not be returning to the 'Glen Heathers' Home.

I was asked by the Social Services Department why I had made this decision and, in response, I prepared and provided a hand-written account describing what I considered to be a catalogue of unacceptable events which had led me to conclude that the level of care which my mother was receiving at the 'Glen Heathers' Home was no longer acceptable to me.

The hand-written account was prepared, by me, during August 1998 and I consider that it represented a truthful statement which dealt with various events and circumstances which I had observed or had become aware of during the months which preceded my mother's admission to the Haslar Hospital.

I will not, for the purposes of this statement, refer in detail to the matters described in that account but I will, by way of introducing the events which followed, make some brief references, drawing on my personal recollections and my notes, to my involvement in the events leading to my mother's admission to the Haslar Hospital on Wednesday the 29th July 1998.

I was a frequent and regular visitor to the 'Glen Heathers' Home whilst my mother was residing there and I played an active role in helping her in her daily routines. My visits were generally daily in the last 8 months of her life.

I recall that I was unable to get to the 'Glen Heathers' Home at lunchtime on Wednesday the 29th July 1998. I telephoned the Home to inform them that I would be going there later in the afternoon.

When I arrived, at approximately 1550 hours, I saw that my mother was lying in an armchair. She appeared to have an anxious expression on her face. I asked a care assistant to help me to move my mother into a more comfortable sitting position which, together, we tried to do but, as a result, my mother screamed out in pain.

Code A

Code A

Signed : L. F. LACK Signature witnessed by : R. J. BURT Detective Chief Inspector 7410

MG11A(T)(cont.)

HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

Continuation of Statement of : **Lesley Frances LACK**

I saw John PERKINS, an RGN and the Home's Matron/Manager, and I asked him if there was anything wrong with my mother which might account for her pain. He told me that she was fine.

I clearly knew that this could not be the case but I was not in a position to do anything more at that time. I had to leave the Home at 1615 hours in order to meet a flight at Southampton Airport. I said that I would return later.

I arrived home, from the Airport, at approximately 1810 hours. I found a message on my telephone answer machine, timed at 1528 hours, from a woman I knew as Code A who was an RGN who worked at the Home. Code A stated that my mother had experienced a fall earlier and, whilst she was alright, she was a bit noisy and upset. Code A asked if I could attend the Home, before teatime, and sit with her, to calm her down.

I immediately telephoned the Home, at approximately 1815 hours, and spoke to Code A I told him about the message from Code A and pointed out that I had seen him, at the Home, after the message had been left on my answer machine.

Code A agreed that this was the case but stated that when he had spoken to me he was not aware of my mother's fall. He stated that he had learned about it during the 1800 hours 'hand over' process when Code A had gone off duty.

I asked Code A about my mother's current condition and he said that she was OK. I told Code A that I would call again later. I had to go out in the meantime.

I returned home at approximately 2030 hours. I found three messages from the Home on my telephone answer machine:

1) 2008 hours - from Code A - stating that my mother was quite agitated and noisy and inviting me to attend and sit with her.

2) 2029 hours - stating that my mother was calling as if she may be in pain. She had been put to bed and consideration was being given to calling a doctor.

3) 2030 hours (approximately) - from a woman named Code A a member of the night staff - stating that she was sorry but she was sure that my mother had a fractured femur. She went on to state that when she had started work she had been told, by Code A to see my mother who had been shouting for ages. Code A stated that when she did so the injury appeared obvious and, as a result, she had called an ambulance.

Code A

Signed : L. F. LACK

Signature witnessed by : Code A

R. J. BURT Detective Chief Inspector 7410

MG11A(T)(cont.)

HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

Continuation of Statement of : **Lesley Frances LACK**

I telephoned the Home and advised the staff that I would meet the ambulance at the Haslar Hospital.

On admission to the Haslar Hospital my mother was 'x' rayed and the diagnosis was confirmed. Furthermore, it was observed that the injury was consistent with my mother having been 'walked' after the fall had occurred. There was a shortening of the limb and an external rotation of the right foot. My mother was extremely upset and was crying and wailing in fear.
I subsequently sought a full explanation from the 'Glen Heathers' Home about the events which occurred on the 29th July 1998. As a result I saw a woman named Code A an RGN and consultant/advisor to the Home.

Code A read to me from several statements which had been obtained from members of staff at the Home. I was not given copies.

During this process I was advised that my mother had fallen at 1450 hours in the dining room.

The statements read to me, by Code A indicated that my mother had been walked to the lounge, at some time after the fall had occurred, and, at some time thereafter, walked to the bedroom from the lounge.

The statements confirmed the following key points:

1) The fall had occurred at 1450 hours.

2) The serious injury which had apparently been sustained during this fall was not identified or even suspected by the staff despite my mother clearly showing signs of being in considerable and sustained pain.

3) My mother was walked on two occasions after apparently sustaining the injury which appears to have seriously aggravated her condition.

4) A doctor was not called to the Home.

5) My mother's condition was not effectively identified until a member of the night staff correctly diagnosed the likely cause of her severe discomfort and pain at or about 2030 hours when an ambulance was called to the Home and she was taken to the Haslar Hospital.

Code A

Signed : L. F. LACK

Code A

Signature witnessed by : R. J. BURT Detective Chief Inspector 7410

MG11A(T)(cont.)

HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

Continuation of Statement of : **Code A**

I can produce a copy of the hand-written notes which I prepared. These notes have attached to them a Hampshire Constabulary exhibit label which I have signed and which bears the reference LFL/1.

Following her admission to the Haslar Hospital, at approximately 2100 hours on Wednesday the 29th July 1998, my mother underwent a surgical operation. This was carried out during the following day, Thursday the 30th July 1998, following a discussion with the consultant who thought my mother should be given the chance to remain ambulant.

My mother received a replacement hip, on her right side, and remained in the Haslar Hospital for a further eleven days until Tuesday the 11th August 1998.

I visited my mother every day during this period and, in my view, when taking into account the serious injury which she had sustained and the trauma she had suffered, my mother appeared to make a good recovery during this period.

Prior to her discharge, and transfer to the Gosport War Memorial Hospital, my mother was responding to physiotherapy, able to walk a short distance with the aid of a zimmer frame and no longer required a catheter. Her medication had been reduced and she was able to recognise family members and make comments to us which made sense.

She was, with encouragement, eating and drinking naturally and as a result the drips, which had facilitated the provision of nourishment after the operation, had been removed.

Significantly, my mother was no longer in need of pain relief. It was quite apparent, to me, that she was free of pain.

Such was the extent of my mother's recovery that it was considered appropriate to discharge her and transfer her to the Gosport War Memorial Hospital where she was admitted to Daedalus Ward on Tuesday the 11th August 1998. This was the first occasion that my mother had been admitted to this particular hospital.

I will now deal with the matters which arose during the following ten days culminating in my mother's death on Friday the 21st August 1998.

In doing so I will draw upon my personal recollections and also refer to a further set of hand-written notes which I prepared, whilst sitting at my mothers bedside, while she was still alive with my sister Gillian MACKENZIE, as I was unhappy with the events that had befallen my mother.

Code A

Signed : L. F. LACK

Signature witnessed by : R. J. BURT Detective Chief Inspector 7410

MG11A(T)(cont.)

HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

Continuation of Statement of : **Lesley Frances LACK**

I telephoned the Complaints Department at Portsmouth Health Care Trust on Wednesday 19th August from Daedulus ward and spoke to Code A in depth. Having listened, she advised me that everything must be in writing. I continued adding to my notes - hence the use of different pens. I prepared these notes on the advice of Code A for the Portsmouth Health Care Trust, to whom I expressed my serious concerns about the care and treatment given to my mother by staff at the Gosport War Memorial Hospital.

The hand-written notes, a copy of which I passed to Code A are in the form of a basic chronology and I incorporated within them a series of questions which focused on particular areas of concern in respect of which I sought an explanation or clarification from the hospital authorities. Following presentation of my notes we were visited on the ward by Code A Code A on 20.8.98.

I produce the original hand-written notes which I prepared comprising of 5 numbered pages. These notes have attached to them a Hampshire Constabulary exhibit label which I have signed and which bears the reference LFL/2.

I am in possession of a further page of notes, in my hand-writing, which I prepared at the time. I cannot now recall whether this additional page was copied to Code A with the other pages. This single page has attached to it a Hampshire Constabulary Exhibit Label bearing the reference LFL/2A which I have signed.

Many of the events and occasions I refer to in this statement took place in the presence of my sister Gillian Mackenzie. The addition to the notes were made when my sister and I read them prior to passing them to Code A as requested. Gillian remained at the hospital with me from 18th to 21st August 1998 inclusive, either of us leaving for very short periods only.

I visited my mother the day of her admission and discussed her present condition with the staff and on the following day after her admission to the Gosport War Memorial Hospital, namely Wednesday the 12th August 1998, I was rather surprised to discover that I could not rouse her. As she was unrousable she could not take nourishment or be kept hydrated.

I enquired among the staff and I was told that my mother had been given the morphine based drug 'Oramorph' for pain. This also surprised me. When my mother had been discharged from the Haslar Hospital, the day before, she had not required pain relief for several days.

I was distressed to observe my mother's deteriorated condition which significantly contrasted with the level of recovery which had been achieved following treatment at the Haslar Hospital during the period after the surgical operation to replace her hip.

Code A

Code A

Signed : L. F. LACK Signature witnessed by : R. J. BURT Detective Chief Inspector 7410

MG11A(T)(cont.)

HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

Continuation of Statement of : **Lesley Frances LACK**

I was told that my mother had been calling out, showing signs of being anxious, and it was believed that she was suffering pain. They did not investigate a possible cause. I consider it likely that she was in need of the toilet.

I became concerned that perhaps the staff at the Gosport War Memorial Hospital may have misinterpreted my mother's anxious and occasionally noisy behaviour. She had been showing signs of dementia for some time, prior to her admission to the Haslar Hospital, and she was prone to becoming very anxious at times particularly when she wanted to use the toilet.

One of the consequences of being rendered unrousable, by the effects of 'Oramorph, was that no fluids could be given to my mother and this, together with the abandonment of other forms of rehabilitation, would have served to inhibit or prevent the recovery process which had begun prior to her admission to the Gosport War Memorial Hospital.

I would like to clarify an important concern I felt at this stage.

I believed that it was possible, having regard to the level of recovery which my mother had achieved upon being discharged from the Haslar Hospital the day before, that her reported behaviour could have been wrongly attributed to the presence of pain as opposed to other possible causes, such as anxiety, which could have been addressed naturally or by the use of alternative and milder forms of medication. I believe that the possible misinterpretation of my mother's behaviour is a particularly significant factor in this case.

In the circumstances which I have just described I consider that it is possible that my mother's signs of anxiety could have been misinterpreted for pain whereas, subsequently, it appears likely that the fact that my mother, after having fallen, and was clearly showing signs of being in pain, these signs were either ignored or dismissed as being the result of her dementia.

During the following day, Thursday the 13th August 1998, I received a telephone call, at approximately 1400 hours, from my daughter, Karen READ, who is a qualified nurse. As a result I went to the Gosport War Memorial Hospital to see my mother.

I arrived at the Gosport War Memorial Hospital at approximately 1545 - 1600 hours. I immediately saw that my mother appeared to be uncomfortable and in pain. She had an anxious expression, was weeping and was calling out. She was sitting in a chair and appeared grossly uncomfortable.

I spoke to several trained and untrained members of staff expressing my concern over my mother's condition. I was told that there was nothing wrong and that her behaviour was the result of her dementia. I was not satisfied with this explanation and I was convinced that my mother was in pain.

Code A

Code A

Signed : L. F. LACK

Signature witnessed by : R. J. BURT Detective Chief Inspector 7410

MG11A(T)(cont.)

HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

Continuation of Statement of : **Lesley Frances LACK**

Later, at approximately 1630 - 1700 hours, a care assistant came into my mother's room. She told me that my mother had fallen from a chair earlier that day.

I immediately enquired if my mother had been examined by a doctor but the care assistant did not know. I also asked if my mother could be x-rayed but I do not recall receiving a response to this request. I was able to give my mother a fruit drink which I had brought with me and she drank it readily. The whole glass.

A little later I saw an RGN who was doing the medicine round at approximately 1730 - 1800 hours. I was, at this time, feeding my mother by tea spooning her with some soup. My mother was quiet then.

The RGN asked me, " Do you think your mother is in pain?" In reply I expressed the view, "Not at the moment while I'm feeding her." I was rather taken aback by the RGN's rather curt reply, "Well you said she was in pain". I replied, "Yes, she has been very uncomfortable since I got here. Do you think she has done some damage?" The RGN replied, "No, she only fell on her bottom from her chair". I was shocked by this seemingly casual and insensitive remark - when this accident could very easily have caused damage and had not been checked.

I remained with my mother until approximately 1945 hours that evening (Thursday the 13th August 1998). After I had fed her she once again became distressed and showed signs of being in considerable pain. She remained in this condition, throughout, until my departure. I left very distressed as my mother was crying out and I could do nothing for her.

After I arrived home I received a telephone call from Daedalus Ward at the Gosport War Memorial Hospital. The caller stated that, "When we put your mother to bed she was in great pain and she may have 'done something'. The doctor feels it's too late to send her to Haslar and our x-ray unit is closed. We will give her 'Oramorph' for the night to keep her pain free and x-ray her in the morning".

I was becoming extremely concerned about what was happening to my mother.

It appeared, to me, at that time, that my mother had suffered a potentially serious fall at some time prior to my daughter's telephone call, to me, at approximately 1400 hours. I have, earlier in this account, referred to conversations which I had, during the afternoon and early evening, with two members of staff who both knew about, and referred to, the fall.

Despite the fact that my elderly mother was known to have suffered a fall, so soon after a hip operation, and then so clearly showed signs of anxiety, discomfort and pain, the reason was not properly explored and diagnosed.

Code A

Signed : L. F. LACK

Signature witnessed by : R. J. BURT Detective Chief Inspector 7410

MG11A(T)(cont.)

HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

Continuation of Statement of : **Lesley Frances LACK**

This, in fact, resulted in what I believe was an avoidable delay of eight hours, in the first instance, before it was acknowledged, at approximately 2130 hours, that my mother, "may have done something".

I reiterate that I was, at that time, advised that the proper facilities (x-ray unit) for diagnosing my mother's condition, at the Gosport War Memorial Hospital, "were closed" and that the doctor, "feels it is too late to send her to Haslar".

Instead, my mother was given 'Oramorph' for pain relief and remained, effectively untreated, at the Gosport War Memorial Hospital overnight.

I strongly believe that the failure, on the part of the staff at the Gosport War Memorial Hospital, to properly and promptly take steps to accurately diagnose my mother's condition, on Thursday the 13th August 1998, and immediately initiate action to effectively deal with the cause by seeking a transfer to the Haslar Hospital where treatment was available, represented an example of a pattern of omission and failure which, ultimately, contributed in her death.

The following morning, Friday the 14th August 1998, I went to the Gosport War Memorial Hospital. I arrived as my mother was being taken, on a trolley, to the x-ray department. She was still deeply under the effects of the 'Oramorph' drug. I accompanied Code A whilst she underwent the x-ray process the associated movements of which caused her great pain.

When the x-ray process was completed we returned to my mother's ward and I was called into an office by Philip, the Ward Manager, where I also saw Dr BARTON. I was told, "Your worst fears of last night appear to be true, we have rung Haslar and they have accepted her back".

My mother was admitted to the Haslar Hospital, for the second time, during the late morning of Friday the 14th August 1998. I accompanied my mother and she was expected. The Consultant was called and he saw my mother in the Casualty Department immediately.

The Consultant showed me the x-rays and the position of my mother's limb, something else which I had observed, the day before, at the Gosport War Memorial Hospital.

My mother's right hip, which had been the subject of a surgical 'replacement' operation 14 days previously, had become dislocated from its socket. Within one hour of being admitted my mother underwent a successful surgical operation to manipulate the hip back into the socket.

This did, indeed, confirm my fears about the care my mother had received. She had fallen, whilst at the Gosport War Memorial Hospital, and it had taken almost 24 hours to secure effective treatment.

Code A

Signed : L. F. LACK

Signature witnessed by : Code A

R. J. BURT Detective Chief Inspector 7410

MG11A(T)(cont.)

HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

Continuation of Statement of : **Lesley Frances LACK**

I remained at the hospital until approximately 10pm.

My mother did not regain consciousness until approximately 0100 hours on Saturday the 15th August 1998 due to the amount of analgesia required for the procedure. I telephoned the ward at this time as I was anxious. The night staff told me she had just regained consciousness.
She was the catheterised so that there was no need to use a slipper pan. She had a drip as she had been given nil by mouth since before the x-ray procedure carried out on Friday the 14th August 1998.

She remained pain free, in a full length leg splint. The Consultant showed me that both legs were level and straight. No analgesia was required and she was able to use a commode for the toilet with weight bare for transfer. My mother began to eat and drink and the drip was removed. Her fluid balance was acceptable. I visited daily.

Such was my mother's progress that during the following day, Sunday the 16th August 1998, she became easily manageable.

The issue I wish to highlight, at this point, is that when my mother's condition was correctly diagnosed and treated her pain and discomfort were removed and she recovered well.

My mother was examined early on Monday the 17th August 1998 when a transfer back to the Gosport War Memorial Hospital was recommended. I contacted the Haslar Hospital by telephone at approximately 0830 hours as requested and was told that my mother would be transferred that morning.

I offered to attend the Haslar Hospital so that I could pack my mother's things and accompany her but I was told that there was, "No need, she is fine".

I arrived at the Gosport War Memorial Hospital at approximately 1045 hours with Gillian MACKENZIE and we were told that the ambulance, carrying my mother, was due at midday or thereabouts.

We returned to the Gosport War Memorial Hospital at approximately 1215 hours.

On entering through the swing doors to the ward I heard my mother screaming. When I arrived at my mother's room a care assistant said, "You try feeding her. I can't do it. She is screaming all the time".

My mother had a staring anxious expression. She was griping her right thigh, at the sight of the surgical operation, tightly.

Code A

Code A

Signed : L. F. LACK Signature witnessed by : R. J. BURT Detective Chief Inspector 7410

MG11A(T)(cont.)

HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

Continuation of Statement of : Code A

She uttered the words, "Do something, do something. The pain, the pain. Don't just stand there. I don't understand it. The pain, the pain, the pain. Sharp, sharp. This is some adventure". Gillian MACKENZIE was present.

An SRN came into the room because of the noise my mother was making. I removed the sheet covering my mother as she lay on her bed and pointed out the awful position she was in. She was lying awkwardly towards the left side and the hips were uneven.

My mother was crying in pain and I said to the RGN, "Can we please move her." We moved her together with our arms together under her lower back and our other arms under her thighs. We placed her squarely on her buttocks and within minutes she had stopped screaming.

I was concerned that my mother's position had not, apparently, been checked when she had been transferred from the ambulance. I was also concerned about the fact that, once again, the source of the pain had not, immediately, been sought.

I left my sister, at the Gosport War Memorial Hospital, at around this time and I went to the Haslar Hospital. This would have been about lunchtime.

I was so appalled at my mother's condition, discomfort and severe pain that I went to the ward in which she had been treated, E3, and enquired about her condition upon discharge earlier that morning.

When I had, earlier that day, telephoned E3 ward and I had been further advised that Code A was eating, drinking, using a commode and able to stand if aided. The Consultant responsible for Code A was, I was told, happy that she could be sent back to the Gosport War Memorial Hospital.

It is, perhaps, worthwhile re-emphasising that this was the level of recovery my mother had achieved on the morning of Monday the 17th August 1998 prior to being discharged from the Haslar Hospital. Whilst she was an elderly and frail lady she was not suffering with a fatal illness. Her discharge notes from Haslar refer to her care for the next 4 weeks, to ensure her progress was maintained.

Upon leaving Haslar Hospital's E3 ward, after confirming the information I had earlier been given, I met the Doctor who had been present in the Casualty Theatre at the time of Code A 's second operation which took place on Friday the 14th August 1998. This Doctor had been with the Consultant when all the procedures were explained to me, upon Code A 's admission, that day. The Doctor asked, "How's your mother?"

Code A

Signed : L. F. LACK Signature witnessed by : R. J. BURT Detective Chief Inspector 7410

Code A

MG11A(T)(cont.)

HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

Continuation of Statement of : **Lesley Frances LACK**

I explained the current position to him in detail. I told him that she was in severe pain since the transfer which had been undertaken a short time earlier. He said, "We've had no referral. Get them to refer her back. We'll see her."

I then returned to the Gosport War Memorial Hospital where I noted that the Charge Nurse Manager frequently checked my mother. He acknowledged my concern and the fact that my mother was obviously in pain.
I asked for my mother to be x-rayed and enquired what had happened between my mother having left the Haslar Hospital and her arrival at the Gosport War Memorial Hospital.

It was acknowledged that "something" had happened. The Charge Nurse was concerned for my mother's pain and analgesia was given three times between her admission and 1800 hours.

Philip, the Ward Manager, agreed that my mother needed an x-ray to establish if further damage had been done to the hip.

The x-ray department refused to act upon forms of authority prepared and signed on behalf of the doctor who was unavailable.

An appointment for x-ray was made for 1545 hours as the Doctor who had been called was expected at approximately 1515 hours.

The Charge Nurse did all he could to expedite this, keeping me informed and constantly checking my mother's obvious severe pain. He administered pain relief in readiness for the x-ray procedure. He was courteous and attentive at all times.

Dr BARTON arrived and I left the room as requested whilst she examined my mother. She stated that whilst she did not think that there was further dislocation the x-ray could go ahead. A review would be conducted later when the result of the x-ray was known.

I accompanied my mother to the x-ray department. My mother remained in pain despite the pain relief which had been administered to her. I was not allowed to accompany her as I had been the previous week . Whilst I waited outside I could hear my mother wailing, while the x-ray was taken.

In due course I returned to the ward and I was told that there was no dislocation but obviously 'something' had happened. I was not given sight of the x-ray.

Code A

Code A

Signed : L. F. LACK

Signature witnessed by : R. J. BURT Detective Chief Inspector 7410

MG11A(T)(cont.)

HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

Continuation of Statement of : **Lesley Frances LACK**

I was told, by either the Ward Manager or Doctor BARTON, that my mother would be given 'Oramorph' for the pain, four hourly, through the night and she would be reviewed in the morning. I told them that Haslar would accept her back but Dr BARTON felt that was inappropriate.

I told Dr BARTON and the Ward Manager that I had been to the Haslar Hospital that morning, explained what was happening, and told them that Haslar would be prepared to re-admit my mother. I considered this was essential so that the 'cause' of my mother's pain could be treated and not simply the pain itself.

Dr BARTON said that, "It was not appropriate for a 91 year old, who had been through two operations, to go back to Haslar Hospital where she would not survive further surgery."

The following day, Tuesday the 18th August 1998, I returned to the Gosport War Memorial Hospital with my sister in the morning. Upon arrival we were told by, the Ward Manager Mr Philip BEED, that whilst my mother had undergone a peaceful night she had, however, developed a massive heamatoma in the vicinity of the operation site which was causing her severe pain.

The plan of management, as explained to us by the Ward Manager, was to use a syringe driver to ensure my mother was pain free at all times so that she would not suffer when washed, moved or changed in the event she should she become incontinent.

The outcome of the use of the syringe driver was explained to my sister and I fully. Drawing on my experience as a nurse I knew that the continuous use of morphine, as a means of relieving her pain, could result in her death. She was, at that time, unconscious from the effects of previous doses of 'Oramorph' and therefore unable to take nourishment by mouth. It was my understanding that it would not have been possible for nourishment to have been given to my mother, by way of a drip, whilst she remained at the Gosport War Memorial Hospital.

As a result of seeing my mother in such great pain I was becoming quite distressed at this stage. My sister asked the Ward Manager, " Are we talking about euthanasia? It's illegal in this country you know." The Ward Manager replied, "Goodness, no, of course not." I was upset and said, "Just let her be pain free".

The syringe driver was applied and my mother was catheterised to ease the nursing of her. She had not had anything by mouth since midday Monday 17th August 1998.

A little later Dr BARTON appeared and confirmed that a haemetoma was present and that this was the kindest way to treat my mother. She also stated, "And the next thing will be a chest infection."

Code A

Code A

Signed : L. F. LACK

Signature witnessed by : **R. J. BURT Detective Chief Inspector 7410**

MG11A(T)(cont.)

HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

Continuation of Statement of : **Lesley Frances LACK**

I considered that this was a totally insensitive remark to make to someone, such as myself, who was experiencing some of the feelings associated with the first stages of bereavement.

I would like to clarify the issue of my 'agreement' to the syringe driver process. It was not a question, in my mind, of 'agreement'.

I wanted my mother's pain to be relieved. I did not 'agree' to my mother being simply subjected to a course of pain relief treatment, at the Gosport War Memorial Hospital, which I knew would effectively prevent steps being taken to facilitate her recovery and would result in her death.

I also wanted my mother to be transferred back to the Haslar Hospital where she had, on two occasions, undergone operations and recovered well. My mother was not, I knew, terminally ill and, with hindsight, perhaps I should have challenged Dr BARTON more strongly on this issue.

In my severe distress I did not but I do believe that my failure to pursue the point more vigorously should not have prevented Dr BARTON from initiating an alternative course of action to that which was taken, namely a referral back to the Haslar Hospital where my mother's condition could have been treated and from where an offer had already been made to do so.

I accept that my mother was unwell and that her physical reserves had been depleted. However she had, during the preceding days and weeks, demonstrated great courage and strength. I believe that she should have been given a further chance of recovery especially in the light of the fact that her condition had, it would seem likely, been aggravated by poor quality service and avoidable delay experienced whilst in the hands of those whose responsibly it was to care for her.

My mother's bodily strength allowed her to survive a further 4 days using her reserves. She suffered kidney failure on the 19th August and no further urine was passed. The same catheter bag remained in place until her death.

Because the syringe driver was deemed to be essential following the night of several doses of pain relief my mother's condition gradually deteriorated during the next few days, as I knew it inevitably would, and she died on Friday the 21st August 1998.

I passed, as I have previously mentioned, a copy of the notes I had prepared (LFL/2) to Mrs HUMPHREY.

In reply I received a letter from Max MILLETT, the Chief Executive of the Portsmouth Health Care NHS Trust, dated the 22nd September 1998.

Code A

Code A

Signed : L. F. LACK Signature witnessed by : R. J. BURT Detective Chief Inspector 7410

MG11A(T)(cont.)

HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

Continuation of Statement of : **Lesley Frances LACK**

I can produce a copy of this letter which has, attached to it, a Hampshire Constabulary exhibit label which I have signed and which bears the reference LFL/3.

Whilst there are a number of issues which cause me concern I would like to make some particular comments on the contents of this letter.

In order to do this I have been provided, by DCI BURT, with a typed copy of the letter (LFL/3). This copy, to which is now attached a Hampshire Constabulary Exhibit Label bearing the reference LFL/3A and signed by me, was constructed to enable me to add hand-written comments which I have done. I feel, however, that I should point out that where I have chosen not to record such a comment this does not imply that I necessarily agree with, or accept, what has been stated.

I have been shown, by DCI BURT, a copy of an Enquiry Report which has attached to it 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 this Enquiry Report (LH/4). The copy, to which is now attached a Hampshire Constabulary Exhibit Label bearing the reference LFL/4 and signed by me, was constructed to enable me to add hand-written comments which I have done. I, once again, 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 have had sight of a Report, prepared by Dr LORD and dated the 22nd December 1998, which has attached to it a Hampshire Constabulary Exhibit Label bearing the reference LH/6 and signed by me.

If this Report is supposed to represent an independent assessment of the treatment which my mother received at the Gosport War Memorial Hospital then I find this difficult to accept.

Dr LORD was the Consultant for Daedalus Ward at the Gosport War Memorial Hospital but, in her own words, "....did not attend to Mrs RICHARDS at all....".

Dr LORD's Report appears to have been prepared by reference, some time after the event, to information, notes and documents supplied by colleagues with whom she worked on a regular basis.

I have been shown, by DCI BURT, a Portsmouth Health Care NHS Trust Risk Event Record. Attached to this document is a Hampshire Constabulary Exhibit Label bearing the reference LH/2 which I have signed.

Code A

Code A

Signed : **L. F. LACK** Signature witnessed by : **R. J. BURT Detective Chief Inspector 7410**

MG11A(T)(cont.)

HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

Continuation of Statement of : **Lesley Frances LACK**

I have examined this document, which comprises of 3 sides of paper, and I would like to make the following observations.

On page 1, at 12 (a) after the words 'Seen by?' there is a hand-written entry, "Dr BRIGG".

I believe that this contradicts information contained in the letter from the Portsmouth Healthcare Trust (LFL/3) dated 22nd September 1998 where, at point (4), it states that Dr BARTON was present on the ward just after my mother's fall.

Furthermore, at 12 (a), there is a further hand-written entry which states, "Advised by telephone - analgesia & RV mane". This may be cross referred to an entry in my mother's Health Care Record (LH/1/C/21) which is dated 13.8.98 and timed at 1300.

At 12 (b) it states, in reply to the question, "Has next of kin been informed? The corresponding "Yes" has been positively ticked and dated 13/8/98. Furthermore it states that I had been informed by telephone.

I was not informed and I was not telephoned. My statement shows I was on the ward and had great difficulty in finding anyone to confirm my mother was injured.

It is my opinion that the Risk Event Record is incorrect. My mother was not seen by Dr BRIGG.

Part 'E' of the Risk Event Record shows that a particular question, which appears among a series of 'tick box' questions and states, " Slipped, tripped or fell on the same level", has been positively answered. In my view this is incorrect. The normal height of the seat would be between 17 and 25 inches so my mother's fall to the ground would have involved a considerable drop.

I have been shown, by DCI Burt, a copy of a Portsmouth Health Care Trust Health Record. Attached to this Health Record is a Hampshire Constabulary Exhibit Label bearing the reference LH/1/C.

This Health Record relates to my mother and I would like to make the following comments in respect of this document.
On the page marked LH/1/C/6, which is a copy of a Discharge Letter from the Royal Hospital Haslar, I note the comment, "She can, however, mobilise fully weight bearing." I wish to highlight the fact that this relates to my mother's condition on the 17th August 1998.

On the page marked LH/1/C/8 there is a copy of a hand-written note, apparently signed by Philip BEED, which is addressed to Haslar A & E and is dated 14th August 1998. In these notes it states, "No change in treatment since transfer to us 11/8/98, except addition of Oramorph etc.

Code A

Signed : **L. F. LACK** Signature witnessed by : **R. J. BURT Detective Chief Inspector 7410**

MG11A(T)(cont.)

HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

Continuation of Statement of : **Lesley Frances LACK**

I would comment that no analgesia was required until the staff at the Gosport War Memorial Hospital first used Oramorph when my mother was agitated and probably in need of the toilet on the 11th August 1998 which was the day of her admission from the Royal Hospital Haslar.

I saw that my mother was deeply unconscious when I visited her on the 12th August 1998. In my view this medication probably affected the opportunity to offer nourishment as early as the 11th August 1998.

On page LH/1/C11 I note, with some concern, an entry under the date of the 11th August 1998, in what I believe is Dr BARTON's hand-writing, the comment, "I am happy for nursing staff to confirm death."

My mother was well and enjoying a good convalescence following a major operation. She was able to eat and drink. She was able to stand whilst requiring help with all daily living events.

Perhaps this comment may be considered, by some, as being 'normal' procedure for aged admissions but not in my experience. Such a question may, perhaps, be considered if the patient was suffering from a terminal illness and death is likely or imminent. The evidence does not suggest that my mother was in this condition.

On the same page (LH/1/C/11) there is an entry under the date of the 14th August 1998 which is once again, I believe, in Dr BARTON's hand-writing. It states, "Fell out of chair last night."

Further reference to the Risk Event Record (LH/2) shows, at point (9), that the accident occurred on the 13th August 1998 at 1330 hours and it will be recalled that the Portsmouth Health Care Trust Letter (LFL/3) states that Dr BARTON was on the ward following accident.

I query whether, in fact, my mother was seen at all.

A further comment, in the same entry, states, "Daughter aware and not happy." I re-iterate that I was "not happy" because I could get nothing done for my mother who was simply given pain relief without any apparent attempt to discover the cause of her discomfort.

Finally, in the same entry, the question is raised by, I believe Dr BARTON, "Is this lady well enough for another surgical procedure?" This question was not, however, raised with me.

On the reverse side of page LH/1/C/11, under an entry dated the 17th August 1998, there are references to my mother's condition following the operation on 14.8.98 as per the nurse's notes of Haslar, not to her condition on 17.8.98.

Code A

Code A

Signed : L. F. LACK

Signature witnessed by : R. J. BURT Detective Chief Inspector 7410

MG11A(T)(cont.)

HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

Continuation of Statement of : **Lesley Frances LACK**

There is a comment, I believe in Dr BARTON's hand-writing, "....now appears peaceful." I know that my mother screamed and cried in the period following her re-admission.

My mother was only 'peaceful' being given Oramorph on 3 occasions which rendered her quiet and unconscious. In fact this treatment had rendered my mother incapable of taking any nourishment from this point and she did not regain consciousness again.

I would like to draw attention to the fact that there are no Doctor's notes from the 18th - 21st August 1998.

On the same page, under the date of the 21st August 1998, there is an entry which, I believe, is also in Dr BARTON's hand-writing which I feel I must challenge. Contrary to what Dr BARTON has written I strongly believe that my mother did not have a rattly chest nor any other symptoms of Brocho-pnuemonia.

On page LH/1/C/21, and on the following 3 pages, also so marked and headed 'Contact Record', I note that no entries appear to have been made over the period of the 11th / 12th August 1998.

On page LH/1/C/21, under an entry dated the 13th August 1998, there are comments which clearly indicate that my mother was not seen by a Doctor or examined by way of X-ray following her fall at 1.30pm that day.

It was not until 7.30pm or 8.30pm that it was appreciated that my mother's hip was the cause of my mother's pain. Telephone contact, only, was made and advice sought and given by a doctor who did not know my mother.

I was present on the ward and repeatedly sought help for my mother. I was casually informed, by a Health Care Assistant, that my mother had indeed had a fall.

In my opinion there was a serious lack of action for a post operative patient in view of her obvious gross "discomfort" which was brought to the attention of all grades of staff by myself. The comment included in the entry, "Daughter informed", may refer to the phone call received after I returned home at approximately about 9pm -10pm that evening.

On the same page, under an entry dated the 17th August 1998, there appears to be a reference to my mother being in pain and distress but no action was taken.

There is an 'added' comment which refers to the fact that when my mother was transferred there was, "No canvas under patient...." In my view this represented a serious breach of work procedures and should be questioned.

Code A

Code A

Signed : L. F. LACK

Signature witnessed by : R. J. BURT Detective Chief Inspector 7410

MG11A(T)(cont.)

HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

Continuation of Statement of : **Lesley Frances LACK**

I consider that the circumstances of my mother's transfer from the Royal Hospital Haslar, to the Gosport War Memorial Hospital, should be the subject of investigation. How was she brought from Haslar? How was she lifted? How was she transferred to her bed? Was the bed moved from the wall? How was she deposited in her bed? And By whom? Who was present?

This was a woman, 2 days post operative, who was transferred on a sheet. How could this have happened? And Why?

Who was informed, and when, as regards her degree of pain which was very obvious when I arrived 30 minutes after this entry was apparently made.

On the following page there is a further entry which is also dated the 17th August 1998 and timed at 1305 hours. This entry does not refer to my mother's awful position, which I observed upon my arrival, or the fact that I asked the RGN to look at the way in which she was lying and to adjust her to be equally on both hips.

It was at this point that I told the staff that the Royal Hospital Haslar would be prepared to re-admit my mother. The Surgeon had said that she should not be in pain.

I once again point to the fact that my mother was pain free and mobilising prior to her transfer.

It should be noted there is no entry, on the 17th or 18th August 1998, regarding the fact that my sister and I were told that our mother had a massive haematoma. I can find no written evidence of this fact.
I see that no contact notes were made on the 20th August 1998.

In an entry dated the 21st August 1998 there is a reference to the fact that, "Daughters visited during morning." I would state that, in fact, we were constantly at the Gosport War Memorial Hospital, day and night, from the 17th August 1998 until the time when my mother died.

I would like to comment, in respect of the Nursing Care Plan, on the 2 pages marked LH/1/C/22, lacks information regarding the events that occurred.

With reference to the pages marked LH/1/C/22/4, headed 'Personal Hygiene' and 'Care Plan', there is, in my opinion, a gross lack of attention to the needs of daily living. Not even face and hands were washed and there are no entries at all on the 17th, 19th or 20th August 1998.

Finally, by reference to the page marked LH/1/C/22/1 and headed 'Nutrition' I comment that, in my opinion, this form is sadly lacking in information.

Code A

Code A

Signed : L. F. LACK

Signature witnessed by : R. J. BURT Detective Chief Inspector 7410

MG11A(T)(cont.)

HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

Continuation of Statement of : **Lesley Frances LACK**

There are only 3 entries in total and no entries at all in respect of the 12th, 17th, 18th, 19th or 20th August 1998.

Furthermore there is no acknowledgement of the fact that my mother was having NIL BY MOUTH due to her induced unconscious state by the giving of pain relief only for 5 days prior to her death and during previous days of the 11th, 12th and 13th August 1998.

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 comment that in my opinion, when comparing it as a residual account of events with the Portsmouth Health Care Trust's Health Record (LH/1/C), it supersedes the latter in terms of quality and content.

Having examined the Medical Record (AF/1/C) I consider it to be totally accurate as regards the condition and treatment/care afforded to my mother Mrs Gladys RICHARDS. There is attention to detail and all information contained therein is as I remember.

I would particularly like to highlight a particular issue and refer to a page in the Medical Record marked (AF/1/C/11).

It should be noted that after my mother's initial admission to the Royal Hospital Haslar, when it was uncertain if she would survive, the Doctor, to his credit, has written, "She is to be kept pain free, hydrated and nourished."
To me this indicated that there was a will, and an intention, to afford to my mother total care whilst she was alive.

I wish to draw attention to the excellent standard of treatment which my mother received while at the Royal Hospital Haslar. She was nursed with care and consideration with, significantly, attention being paid to hydration and nourishment. There was an expectation, for the immediate future, on her transfer to the Gosport War Memorial Hospital.

In my view this is in direct contrast, in all aspects, to the standard of care and attention which my mother received at the Gosport War Memorial Hospital during the last 6 days of her life the most notable feature being the refusal to refer her back, once again, to the Royal Hospital Haslar when an offer had been received to accept her.

Code A

Code A

Signed : L. F. LACK

Signature witnessed by : R. J. BURT Detective Chief Inspector 7410

MG11T(2)

HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

Statement of : **Lesley Frances LACK**

Home address : **Code A**

Home telephone No. : Code A Business telephone No. : **N/A**

Sex : **Female** Date and place of birth : Code A

Maiden name : **RICHARDS** Height : **5'2"** Identity Code : **IC1**

Dates to be avoided. Delete dates of non-availability of witness (not police officers)

Month of :							Month of :							Month of :						
1	2	3	4	5	6	7	1	2	3	4	5	6	7	1	2	3	4	5	6	7
8	9	10	11	12	13	14	8	9	10	11	12	13	14	8	9	10	11	12	13	14
15	16	17	18	19	20	21	15	16	17	18	19	20	21	15	16	17	18	19	20	21
22	23	24	25	26	27	28	22	23	24	25	26	27	28	22	23	24	25	26	27	28
29	30	31					29	30	31					29	30	31				
Month of :							Month of :							Month of :						
1	2	3	4	5	6	7	1	2	3	4	5	6	7	1	2	3	4	5	6	7
8	9	10	11	12	13	14	8	9	10	11	12	13	14	8	9	10	11	12	13	14
15	16	17	18	19	20	21	15	16	17	18	19	20	21	15	16	17	18	19	20	21
22	23	24	25	26	27	28	22	23	24	25	26	27	28	22	23	24	25	26	27	28
29	30	31					29	30	31					29	30	31				

Contact point, if different from above : **N/A**

Address : **N/A**

Telephone No. : **N/A**

STATEMENT TAKEN BY : **R. J. BURT DCI 7410**

Station : **Support Headquarters, Fratton Police Station, Portsmouth.**

Time statement taken : **During a period of research and consultation prior to date of signature.**

Place statement taken : Code A

Code A

Signed : **L. F. LACK** Signature witnessed by : **R. J. BURT Detective Chief Inspector 7410**

Code A

54
161

MG11(T)

HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

Statement of : **Mrs Gillian MACKENZIE**

Age if under 18 : **Over 18** (if over 18 insert 'over 18')

Occupation : Housewife (previously Personnel Manager) Retired

This statement (consisting of pages each signed by me) is true to the best of my knowledge and belief and I make it knowing that, if it is tendered in evidence, I shall be liable to prosecution if I have wilfully stated in it anything which I know to be false or do not believe to be true.

Signature : Code A **Dated the** March 6 2000

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.

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 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.

Code A

Signed : Gillian MacKenzie Signature witnessed by : _____

MG11A(T)(cont.)

HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

Continuation of Statement of : **Mrs Gillian MACKENZIE**

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 Code A 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, 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.

Gillian M. MacKenzie

Signed : Gillian MacKenzie Signature witnessed by : _____

MG11A(T)(cont.)

HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

Continuation of Statement of : **Mrs Gillian MACKENZIE**

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.

Code A

Signed : Gillian MacKenzie Signature witnessed by : _____

MG11A(T)(cont.)

HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

Continuation of Statement of : **Mrs Gillian MACKENZIE**

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 my 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.

Signed : Gillian MacKenzie Signature witnessed by : _____

MG11A(T)(cont.)

HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

Continuation of Statement of : **Mrs Gillian MACKENZIE**

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 late.

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

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).

MG11A(T)(cont.)

HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

Continuation of Statement of : **Mrs Gillian MACKENZIE**

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 show 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.

Signed : Gillian MacKenzie Signature witnessed by : _____

MG11A(T)(cont.)

HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

Continuation of Statement of : **Mrs Gillian MACKENZIE**

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 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".

Signed : Gillian MacKenzie Signature witnessed by : _____

MG11A(T)(cont.)

HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

Continuation of Statement of : **Mrs Gillian MACKENZIE**

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".

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 by 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.

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 haemetoma 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.

Signed : Gillian MacKenzie Signature witnessed by : _____

MG11A(T)(cont.)

HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

Continuation of Statement of : **Mrs Gillian MACKENZIE**

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 haemetoma 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.

Signed : Gillian MacKenzie Signature witnessed by : _____

MG11A(T)(cont.)

HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

Continuation of Statement of : **Mrs Gillian MACKENZIE**

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 the Wednesday night my sister also sat in with me all night long and we both remained, continuously, until twenty past nine 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 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.

Signed : Gillian MacKenzie Signature witnessed by : _____

MG11A(T)(cont.)

HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

Continuation of Statement of : **Mrs Gillian MACKENZIE**

I think that she was dehydrated and, with the Diamorphine, this was probably the cause of death although, of course, with a haemetoma, 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 haemetoma 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 haemetoma 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 haemetoma 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.

Signed : Gillian MacKenzie Signature witnessed by : _____

MG11A(T)(cont.)

HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

Continuation of Statement of : **Mrs Gillian MACKENZIE**

In my view a Consultant's opinion should have been sought when the haemetoma was discovered

It is also my view that Dr BARTON's decision not to refer our mother back to the 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 hand-written notes bearing a 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 and 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.

Signed : Gillian MacKenzie Signature witnessed by : _____

MG11A(T)(cont.)

HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

Continuation of Statement of : **Mrs Gillian MACKENZIE**

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 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, 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.

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.

Signed : Gillian MacKenzie Signature witnessed by : _____

MG11A(T)(cont.)

HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

Continuation of Statement of : **Mrs Gillian MACKENZIE**

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 in 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.

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 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 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.

Signed : Gillian MacKenzie Signature witnessed by : _____

MG11A(T)(cont.)

HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

Continuation of Statement of : **Mrs Gillian MACKENZIE**

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 Code A on the 19th August 1998.

The response was in the form of a letter, dated 22nd September 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 a 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, Code A 's office. I told her or Barbara ROBINSON, who was possibly dealing with the matter in Code A '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).

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.

Code A

Signed : Gillian MacKenzie Signature witnessed by : _____

MG11A(T)(cont.)

HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

Continuation of Statement of : **Mrs Gillian MACKENZIE**

When I received a copy of the letter from the Portsmouth Health Care Trust, commenting on the points raised in 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 13:30 on Thursday, 13th August 1998, though there was no 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 13:30 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 note that in reply to the question, "Who attended her?" There is a response, "She was attended by a Staff Nurse Jenny BREWER 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.

Signed : Gillian MacKenzie Signature witnessed by : _____

MG11A(T)(cont.)

HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

Continuation of Statement of : **Mrs Gillian MACKENZIE**

"Your mother had been given medication, prescribed by Doctor 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 Doctor 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 Doctor 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, re-iterated 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 Jean, I think, and one is named Linda. ~~They~~ LINDA told me that when my mother returned to the Gosport War Memorial Hospital, from the Haslar Hospital, on Monday 17th August 1998, they were not happy as she seemed to be in pain. They believed that there was a problem and they went to get GMH

Signed : Gillian MacKenzie Signature witnessed by : _____

MG11A(T)(cont.)

HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

Continuation of Statement of : **Mrs Gillian MACKENZIE**

professional advice. I believe that this was at a quarter to twelve. My sister and I did not arrive until a quarter past twelve.

If, as the reply to our question suggests, Staff Nurse COUCHMAN, in fact, attended to my mother at 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, 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 an 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 been transported on a stretcher. When I later spoke to the two care workers one of them, Linda, 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.

Code A

Signed : Gillian MacKenzie Signature witnessed by : _____

MG11A(T)(cont.)

HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

Continuation of Statement of : **Mrs Gillian MACKENZIE**

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, "Doctor 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 haemetoma would have required a general anaesthetic...etc". This is not true. That was never discussed. The only discussion we had about the haemetoma was with Philip who said nothing could be done except give her pain relief to aid her in dying.

My sister and I were not consulted, whatsoever. When they saw that she had a haemetoma they should have sent her back to the Haslar Hospital there and then. We were not told that our mother had a heamatoma until the Tuesday morning.

I feel, very strongly, that this reply represents an attempt to cover up the truth, by Doctor 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 a Portsmouth Health Care Trust Health Record which relates to my mother. It bears a Hampshire Constabulary Exhibit Label, marked LH/1.C.

Signed : Gillian MacKenzie Signature witnessed by : _____

MG11A(T)(cont.)

HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

Continuation of Statement of : **Mrs Gillian MACKENZIE**

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 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, i.e. 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

MG11A(T)(cont.)

HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

Continuation of Statement of : **Mrs Gillian MACKENZIE**

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.?

I move to LH/1/C/9 which is a letter written by a 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 Doctor BARTON. In an entry, dated 11th August 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".

Signed : Gillian MacKenzie Signature witnessed by : _____

MG11A(T)(cont.)

HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

Continuation of Statement of : **Mrs Gillian MACKENZIE**

There was no indication, from the staff at the Haslar Hospital, that my mother was anywhere near death. Why should Doctor 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, "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 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.

Moving to LH/1/C/14 I note an entry, dated 11th August 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'.

Signed : Gillian MacKenzie Signature witnessed by : _____

MG11A(T)(cont.)

HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

Continuation of Statement of : **Mrs Gillian MACKENZIE**

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 which is timed at 1300 hours. It states, "Found on floor at 13.30hrs 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 tranquilisers.

Signed : Gillian MacKenzie Signature witnessed by : _____

MG11A(T)(cont.)

HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

Continuation of Statement of : **Mrs Gillian MACKENZIE**

Further, on LH/1/C/21, under the date 17th August 1998 and timed 1148 hrs, there is an entry which states, "Returned from R.N. 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 been admitted, and her leg was certainly not straight. There is a further entry, "No follow up unless complications." Surely a haemetoma is a serious complication.

Further, on LH/1/C/21, under the date 18th August 1998 and timed 'a.m.', "Reviewed by Doctor 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 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 haemetoma 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.

Signed : Gillian MacKenzie Signature witnessed by : _____

MG11A(T)(cont.)

HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

Continuation of Statement of : **Mrs Gillian MACKENZIE**

Further, on LH/1/C/21, under the date 21st August 1998, ..Code A 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, 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 to it a Hampshire Constabulary Exhibit Label bearing the reference LH/4, which I have signed.

Signed : Gillian MacKenzie Code A Signature witnessed by : _____

MG11A(T)(cont.)

HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

Continuation of Statement of : **Mrs Gillian MACKENZIE**

If this Report purports to be an objective assessment of the medical and nursing care and attention given to my mother at the 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 a Hampshire Constabulary Exhibit Label bearing the reference GM/2 and signed by me, was constructed to enable me to add hand-written 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 before hand, my mother was not seen by a doctor.

On the 18th August 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. 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.

Signed : Gillian MacKenzie Signature witnessed by : _____

MG11A(T)(cont.)

HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

Continuation of Statement of : **Mrs Gillian MACKENZIE**

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 heamatoma.

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 heamatoma on the 17th August 1998 or, indeed, afterwards.

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

Code A

Signed : Gillian MacKenzie Signature witnessed by : _____

MG11T(2)

HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

Statement of : **Mrs Gillian MACKENZIE**

Home address : **Code A**

Home telephone No. : **Code A** Business telephone No. : **N/A**

Sex : **Female** Date and place of birth : **Code A**

Maiden name : **RICHARDS** Height : **5'6"** Identity Code : **IC1**

Dates to be avoided. Delete dates of non-availability of witness (not police officers)

Month of : April							Month of : May							Month of : June						
1	2	3	4	5	6	7	1	2	3	4	5	6	7	1	2	3	4	5	6	7
8	9	10	11	~~12~~	13	~~14~~	8	9	~~10~~	11	12	13	~~14~~	8	~~9~~	10	11	12	13	14
15	16	17	~~18~~	19	20	21	15	16	17	18	19	20	21	~~15~~	16	17	18	19	20	21
22	23	24	25	26	27	28	~~22~~	~~23~~	~~24~~	~~25~~	~~26~~	~~27~~	~~28~~	22	23	24	25	26	27	28
29	~~30~~	31					29	30	31					29	30	31				
Month of :							Month of :							Month of :						
1	2	3	4	5	6	7	1	2	3	4	5	6	7	1	2	3	4	5	6	7
8	9	10	11	12	13	14	8	9	10	11	12	13	14	8	9	10	11	12	13	14
15	16	17	18	19	20	21	15	16	17	18	19	20	21	15	16	17	18	19	20	21
22	23	24	25	26	27	28	22	23	24	25	26	27	28	22	23	24	25	26	27	28
29	30	31					29	30	31					29	30	31				

Contact point, if different from above : **N/A**

Address : **N/A**

Telephone No. : **N/A**

STATEMENT TAKEN BY : **Detective Chief Inspector R J BURT**

Station : **Major Crime Complex, Support HQ, FRATTON, PORTSMOUTH.**

Time statement taken : **During a period of research and consultation prior to signature.**

Place statement taken : **Code A**

Signed : **Gillian MacKenzie** Signature witnessed by : _____

Code A

-JUN-2001 10:54 INCIDENT ROOM RF

Code A P.01

HAMPSHIRE CONSTABULARY

FAX

Major Crime Complex
Kingston Crescent Police Station
North End
Portsmouth
Hampshire
PO2 8BU

TO	Code A	FROM	Code A		
OF	GMC	TEL	Code A	FAX	Code A
TEL		FAX	Code A	DATE	12th June 01
OR					

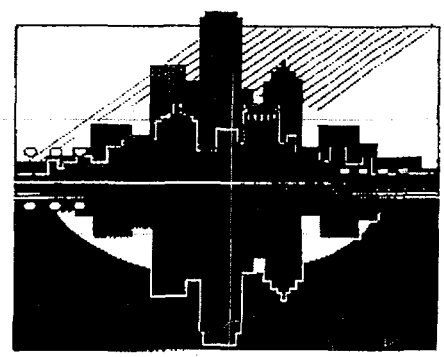
Location Code *(For internal use only)* plus Extension Numbers

Pages (inc)	12	Acknowledgement required please		TEL	Code A
FAX	Code A				

Code A

As promised – Dr BARTONS prepared statement

Code A



Your reference

In reply please quote **JS/2000/2047**

Please address your reply to Fitness to Practise Directorate
Fax Code A

13 June 2001

GENERAL MEDICAL COUNCIL
Protecting patients, guiding doctors

Personal
Special Delivery: First Class

Dr (Mrs) J A Barton

Code A

Dear **Code A**

I am writing to notify you that a person referred to in rule 4(1) ("the medical screener") of the General Medical Council Preliminary Proceedings Committee and Professional Conduct Committee (Procedure) Rules 1998[(a)] has considered information received by the GMC about your conduct.

Copies of the information received are attached, as listed in the index to the bundle.

The member, exercising his powers under rule 4 of the General Medical Council (Interim Orders Committee)(Procedure) Rules 2000, considers that the circumstances are such that you should be invited to appear before the Interim Orders Committee in order that it may consider whether it is necessary for the protection of the members of the public, or is otherwise in the public interest, or in your own interests, that an interim order should be made suspending your registration, or imposing conditions upon your registration, for a period not exceeding eighteen months, in exercise of their powers under section 41A(1) of the Medical Act 1983 as amended.

The screener has reached this decision after considering that the information received from Hampshire Constabulary is of such a nature that it may be both in the public interest and in your own interest that your registration to be restricted whilst those matters are resolved.

You are invited to appear before the Committee at 15:00 on Thursday 21 June 2001 at the Council's offices at 44 Hallam Street, London, W1, if you so wish, to address the Committee on whether such an order should be made in your case. You may, if you wish, be represented by Counsel, or a solicitor, or by a member of your family, or by a representative of any professional organisation of which you may be a member. You may also be accompanied by not more than one medical adviser. The Committee is, however, empowered to make an order in relation to your registration irrespective of whether or not you are present or represented.

178 Great Portland Street London W1W 5JE Telephone 020 7580 7642 Fax 020 7915 3641
email gmc@gmc-uk.org www.gmc-uk.org

You are invited to submit observations on the case in writing. Any observations will be circulated to the IOC before they consider your case. Your observations should be marked for the attention of Code A Committee Section (fax no Code A Code A.

You are invited to state in writing whether you propose to attend the meeting, whether you will be represented or accompanied as indicated above, and if so, by whom.

The Interim Orders Committee normally meets in private but you may if you wish, under the provisions of rule 9 of the Procedure Rules, direct that the meeting should be held in public. If you wish for the meeting to be held in public could you please notify Code A Committee Section (fax number as above), as soon as possible.

If you intend to consult your medical defence society, or to take other legal advice, you should do so without delay.

I enclose copies of the relevant provisions of the Medical Act, the Interim Orders Committee Procedure Rules, a paper about our fitness to practice procedures and a paper about the procedures of the Interim Orders Committee.

The documents enclosed with this letter may contain confidential information. This material is sent to you solely to enable you to prepare for this hearing. The documents must not be disclosed to anyone else, except for the purpose of helping you to prepare your defence.

In accordance with Section 35A(2) of the Medical Act 1983 (as amended), you are required to inform us, within 7 days of receipt of this letter, of the name and address of all of your current employers including the Health Authority/Trust with which you have a service agreement, any locum agencies with whom you are registered, and the hospital/surgery at which you are currently working. If you engage in any non-NHS work, you are also required to notify us, within the same period of time, of the name of the organisation/hospital by which you are employed, or have any working arrangements.

Please will you write personally to acknowledge receipt of this letter quoting the reference above.

Code A

Please quote our reference when communicating with us about this matter

Our ref: ISPB/EG-SC/9900079.Legal
Your ref: FPD/2000/2047
14 June 2001

THE MDU

PRIVATE AND CONFIDENTIAL

Code A
Fitness to Practise Directorate
General Medical Council
178 Great Portland Street
London
W1W 5JE

MDU Services Limited
230 Blackfriars Road
London
SE1 8PJ

DX No. 36505 Lambeth

Legal Department of the MDU

Telephone: 020 7202 1500
Fax: 020 7202 1663

Website www.the-mdu.com

BY POST AND BY FAX TO FAX NUMBER: Code A

Dear Code A

Re: Dr Jane Anne Barton – Interim Orders Committee 21 June 2001

Thank you for your letter of today's date by hand with the various papers concerning Dr Barton. Can I also thank you for taking the time trouble to liaise with me yesterday to let me know of the fact that the Screener had determined that Code A 's case should be referred to the Interim Orders Committee.

Having had an opportunity to consider the material it appears that the matter did not progress from 20 September 2000 when Detective Chief Inspector Burt wrote to the Fitness to Practise Directorate until some time the following year. As you will appreciate, the next documentation made available to me now is the letter from Code A of 6 June 2001. I would be grateful if you could arrange for me to be provided with an explanation for that very significant interval of time, indicating precisely what steps were undertaken to investigate the matter if any.

As you will appreciate, Dr Barton is entitled to be made aware of the documentation which was considered by the Screener in reaching his/her decision to refer this matter to the Interim Orders Committee. I would be grateful if you could let me know precisely what documentation was considered by the Screener, and in the event that documentation was considered beyond the material made available to me now, if you could provide me with that documentation immediately.

Further, Dr Barton is entitled to receive written reasons for the decision of the Screener to refer this matter and I would be grateful once again if written reasons could be supplied immediately, bearing in mind the proximity of the Hearing.

Our ref : ISPB/EG-SC/9900079.Legal
Your ref : FPD/2000/2047
14 June 2001

I look forward to hearing from you as soon as possible.

Yours sincerely

Code A

15 JUN 2001

In reply please quote **FPD/2000/2047**

14 June 2001

Courier: Private & Confidential

Code A
Medical Defence Union
230 Blackfriars Road
London
SE1 8PJ

GENERAL MEDICAL COUNCIL
Protecting patients, guiding doctors

Dear Code A

Dr Jane Ann BARTON (Code A

Further to our telephone conversation yesterday, please find enclosed a copy of the papers relating to the above named doctor.

If you require any further information, please contact me.

Yours sincerely

Code A

178 Great Portland Street London W1W 5JE Telephone 020 7580 7642 Fax 020 7915 3641
email gmc@gmc-uk.org www.gmc-uk.org

Code A

General Medical Council
178, Great Portland Street
London W1W 5JE

Dr Jane Barton

Code A

Reference JS/2000/2047

14th June 2001

Dear Code A

I am writing to acknowledge receipt of your letter, reference above.

I intend to attend the meeting on Thursday 21st June 2001, accompanied by my barrister.

I am a self employed General Practtitioner with the Isle of Wight, Portsmouth and South East Hants Health Authority.

I am also currently employed as the Chair of the Gosport Primary Care Group, a sub committee of the above Health authority.

Code A

Dr Jane Barton

Your reference

In reply please quote **JS/2000/2047**

Please address your reply to Fitness to Practise Directorate
Fax Code A

19 June 2001

Confidential: By Fax

GENERAL MEDICAL COUNCIL
Protecting patients, guiding doctors

Code A
Solicitor
MDU Services Limited
230 Blackfriars Road
London SE1 8PJ

Dear Code A

Dr Jane A BARTON

I am writing further to your faxed letter dated 14 June 2001.

In relation to the first point in your letter, after we received the letter dated 20 September 2000 from the police we made contact with them requesting further information. They supplied to us, on 6 June 2001, the documentation which was served on Dr Barton with the Notice of Referral to the IOC dated 13 June 2001.

The Screener, in reaching his decision, considered the documentation which was supplied to us by the police on 6 June 2001 and which was served on Dr Barton on 13 June 2001.

The Screener decided to refer this matter to the IOC because he felt that the information from Hampshire Constabulary is of such a nature that it may be both in the public interest and in Dr Barton's own interest that her registration be restricted whilst matters are resolved.

Yours sincerely

Code A

Code A

178 Great Portland Street London W1W 5JE Telephone 020 7580 7642 Fax 020 7915 3641
email gmc@gmc-uk.org www.gmc-uk.org

Please quote our reference when communicating with us about this matter

Our ref : ISPB/EG-GP/9900079.Legal
Your ref :
19 June 2001

THE MDU

PRIVATE AND CONFIDENTIAL

Code A
Fitness To Practise Directorate
The General Medical Council
178 Great Portland Street
London
W1W 5JE

MDU Services Limited
230 Blackfriars Road
London
SE1 8PJ

DX No. 36505 Lambeth

Legal Department of the MDU

Telephone: 020 7202 1500
Fax: 020 7202 1663

Website www.the-mdu.com

BY POST AND BY FAX TO FAX NUMBER: Code A

Dear Code A

Re: Dr Jane Barton – Interim Orders Committee, 21 June 2001

Thank you for your letter of today's date by fax, and I am grateful for the information you have provided.

I would be grateful if you could help me with some further clarification in relation to the second paragraph of your letter. It would appear that, having received the letter dated 20 September 2000, the General Medical Council then requested information from the police, presumably shortly after that date. I would be grateful if you could confirm that that indeed is the case.

It would seem then that the police failed to respond until 6 June 2001. Again, I would be grateful if you could confirm if that is indeed the case, and if not, let me know of the intervening correspondence or communication.

I look forward to hearing from you as soon as possible.

Yours sincerely

Code A

Code A

12 July 2001

NAT14181604/23

Direct line: Code A

GMC
RECEIVED
13 JUL 2001
FEE
O/D

Royal Mail

Customer Service Centre
Slindon Street
PORTSMOUTH
PO1 1AA

Tel: 0845 7740 740
Website www.royalmail.com

Text Phone 0845 600 0606
(for the deaf and hard of hearing)

Code A
GMC
178-202 Great Portland Street
LONDON
W1W 5JE

Dear Code A

Thank you for your enquiry of 10 July regarding a Special Delivery letter number SJ0581 9662 9GB which you sent to Doctor J A Barton, Code A
Code A

I am pleased to enclose a copy of the receipting signature that was obtained when the letter was delivered on 28 June 2001.

Yours sincerely

Code A

To ensure that we maintain the highest possible standards, the service we provide to you is monitored on our behalf by a research agency. Each month telephone interviews are conducted with a sample of the customers with whom we have been in contact. If you would prefer not to be contacted please call Freephone 0800 652 5900 within 7 days of the date of this letter and quote the reference above.

Royal Mail

CONFIRMING YOUR DELIVERY

28/6/10
Date stamp

Affix the item barcode number and enter the time of delivery, or attempted delivery. The recipient must sign and print their name before the item is handed over.

Confirmed on track/trace
PHG initials 3

Walk		Number of items for delivery		Number of items undelivered	
ID	Name	Priority	Recorded	Returned	Pouched off
0102C	CALLORS				

1 Time

RA
Barcode here
7961 7552 4GB

2 Time

SJ
0581 9662 9GB 1150

3 Time

SJ
0736 3436 1GB 1155

4 Time

SJ
0736 3434 4GB 1155

Code A

Retain for one year P4550 Revised October 98 PRI 498024

Your reference

In reply please quote Code A

Please address your reply to Fitness to Practise Directorate
Fax Code A

22 June 2001

GENERAL MEDICAL COUNCIL
Protecting patients, guiding doctors

Confidential: By Fax

Code A
Solicitor
MDU Services Limited
230 Blackfriars Road
London SE1 8PJ

Dear Code A

Dr Jane A BARTON

Please accept my apologies for misleading you, Dr Barton and your Counsel about the documentation the Screener saw when he decided to refer Dr Barton's case to the IOC.

I overlooked the fact the Dr Barton's prepared statement to the police had come in separately on the fax machine on 12 June 2001. This was seen by the Screener, along with the other material which came in on 6 June 2001, when he considered the case on 12 June 2001. As previously stated the Screener saw that which was served on Dr Barton on 13 June 2001.

I apologise for any distress and inconvenience caused to Dr Barton and would like to assure that I did not deliberately intend to mislead you, Dr Barton or the Committee.

Yours sincerely

Code A

178 Great Portland Street London W1W 5JE Telephone 020 7580 7642 Fax 020 7915 3641
email gmc@gmc-uk.org www.gmc-uk.org

E:\C\IOC\FOLLOWUP\BARTON

Your reference

In reply please quote RC/HW/2000/2047

Please address your reply to the Committee Section FPD
Fax Code A

GENERAL MEDICAL COUNCIL
Protecting patients, guiding doctors

25 June 2001

Special Delivery: Personal

Dr J A Barton
11 Village Road
Alverstoke
Gosport
Hampshire
PO12 2LD

Dear Code A

I am writing to confirm that, at the conclusion of the proceedings before the Interim Orders Committee on 21 June 2001 the Chairman announced the Committee's determination as follows:

> "Dr Barton : The Committee has carefully considered all the evidence before it today.
>
> The Committee has determined that it is not satisfied it is necessary for the protection of members of the public, in the public interest or in your own interests that an order under Section 41A of the Medical Act 1983 should be made in relation to your registration."

Yours sincerely

Code A

178 Great Portland Street London W1W 5JE Telephone 020 7580 7642 Fax 020 7915 3641
email gmc@gmc-uk.org www.gmc-uk.org

In reply please quote NV\21JuneIOC

Please address your reply to the Committee Section FPD
Fax Code A

25 June 2001

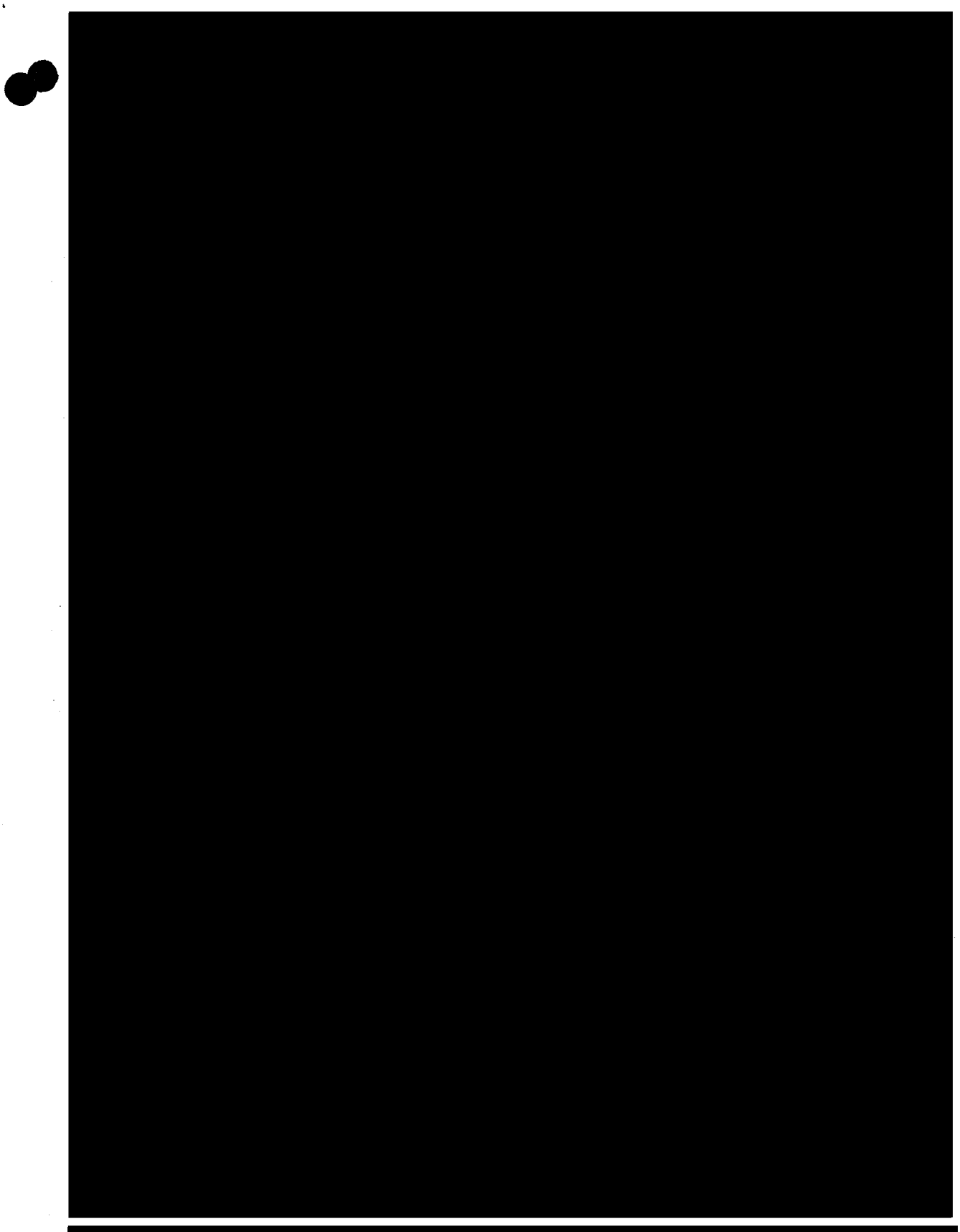
By fax Code A **and**
First Class: Confidential

Code A
NHS Executive
Room 2W10
Quarry House
Leeds LS2 7UE

Dear Code A

I am writing to confirm the decisions taken by the GMC's Interim Orders Committee at its meeting on 21 June 2001. The decisions were as follows:

[redacted]



[redacted]

Name: BARTON, Jane Ann

Registration number: Code A

Registered address: Code A

Code A

Qualifications: MB BCh 1972 Oxford

Decision: No order made

In new cases, the orders will be subject to review within six months of coming into force, and review cases will be subject to further review within three months.

Yours sincerely

Code A

SUNDAY TELEGRAPH
29/07/01

Police investigate nine deaths at cottage hospital

BY DAVID BAMBER
Home Affairs Correspondent

DETECTIVES ARE investigating the deaths of nine patients at a cottage hospital following complaints from relatives, *The Sunday Telegraph* has learnt.

The inquiry into the fatalities, at the Gosport War Memorial Hospital, near Portsmouth, was prompted by concerns about the death of an elderly woman who was prescribed diamorphine, the pain-killing drug.

Other families contacted Hampshire Police after the initial complaint. The fatalities are said to have all taken place over three years.

A spokesman for Hampshire Police last night confirmed that investigations were continuing. One complaint has already been investigated and a file sent to the Crown Prosecution Service.

The spokesman said: "We have been contacted by the relatives of nine people who were concerned about deaths of their relatives at the hospital. The situation now is that we are speaking to four of those people about, what their concerns are and are making preliminary inquiries."

Ian Piper, the operational director of Portsmouth Health-Care NHS Trust which runs the hospital, confirmed that the authority was helping police with their investigations.

He said: "I am aware that the police are undertaking preliminary inquiries into a number of cases. Eight people have come forward in addition to the original complainant.

"The trust will assist the police with their preliminary inquiries. We have every confidence in the staff at the hospital and the care they provide."

Gillian Mackenzie, whose 91-year-old mother died at the hospital after being prescribed diamorphine, contacted police in 1998. A file on the case has been sent by Hampshire CID to the Crown Prosecution Service.

Solicitors at the CPS have so far recommended that there is insufficient evidence for charges of unlawful killing to be brought, although the case has not been closed by the police.

Mrs Mackenzie, 63, of Eastbourne, East Sussex, said: "I am a realistic woman. I knew there was a chance of my mother dying when she was admitted to hospital. It is the manner she died that shocked me. I will never know what would have happened if she had not been prescribed diamorphine but we must ensure that all the circumstances of these deaths are fully explained."

She added: "I am glad the police are investigating these cases at the hospital. They are all similar to my mother's and we must get to the bottom of what was happening."

Code A

File note of telephone conversation.

I spoke with CPS lawyer Paul Close who told me that the CPS had decided not to pursue any matters with Dr Barton and she would not be charged with any offences in respect of the death of Gladys Richards.

Code A

7 August 2001.

File note of telephone conversation.

Det Supt James rang to say that the police are going to investigate the other 9/10 suspicious deaths at the Gosport War Memorial, and they will be seeking an expert opinion but will not be using Professor Livesley again.

Det Supt said that he would confirm the above in writing but hopes to be in a position to let all parties know what is happening by the end of September 2001.

Code A

13 August 2001.

HAMPSHIRE Constabulary

Paul R. Kernaghan QPM LL.B MA DPM MCIPD
Chief Constable

Major Incident Complex
Kingston Crescent
North End
Portsmouth
PO2 8BU

Our Ref. : MIC/Det.Supt/JJ/DM

Your Ref. : 3000/3047-7MH

Tel. :
Direct Dial : Code A
Fax. :

14 August 2001

Code A
Fitness to Practice Directorate
General Medical Council
178 Great Portland Street
LONDON
W1N 7JJ

Dear Code A

Re: Dr Jane BARTON

I am writing to notify you that on Friday 10th August 2001, I received written confirmation from the Crown Prosecution Service informing me of Senior Treasury Counsel's advice regarding the matters about which Dr BARTON was interviewed by the Police.

The advice is that, based on the papers submitted to the Crown Prosecution Service by Hampshire Constabulary, there is insufficient evidence to support a viable prosecution against Dr BARTON with regard to the death of Mrs Gladys RICHARDS.

As Senior Investigating Officer for the enquiry I have accepted this advice.

In the absence of any other significant evidence being forthcoming no further action will be taken against Dr BARTON in relation to the death of Mrs Gladys RICHARDS.

I must advise you that following publicity concerning the enquiry into Mrs RICHARDS death a number of members of the public have contacted the enquiry team expressing concerns about the circumstances attendant to the deaths of relatives who had died at the Gosport War Memorial Hospital. I must further advise you that we are conducting preliminary enquiries to determine whether or not these other matters should be the subject of a more intensive police investigation.

HAMPSHIRE Constabulary

I anticipate that these enquiries will be completed within the next six to eight weeks. I will advise you at the earliest opportunity of the outcome of our investigation.

Code A

J JAMES
Detective Superintendent

Your reference

In reply please quote

Code A

GENERAL MEDICAL COUNCIL

Protecting patients, guiding doctors

17 August 2001

J James
Detective Superintendent
Hampshire Constabulary
Major Incident Complex
Kingston Crescent
North End
Portsmouth PO2 8BU

Dear Detective Superintendent James

Thank you for your letter of 14 August 2001, the contents of which have been noted. We shall await your further correspondence and in particular the outcome of the further investigations.

Yours sincerely

Code A

178 Great Portland Street London W1W 5JE Telephone 020 7580 7642 Fax 020 7915 3641
email gmc@gmc-uk.org www.gmc-uk.org

Your reference Code A

In reply please quote: 2000/2047

7 February 2002

First Class Post

Det Supt James
Major Incident Complex
Kingston Crescent
North End
Portsmouth
PO2 8BU

GENERAL MEDICAL COUNCIL
Protecting patients, guiding doctors

Dear Det Supt James

Dr Jane Barton

I write further to your previous correspondence with my colleague Code A regarding the above case. Code A has now moved to a new role within the GMC and responsibility for this case has passed to me. I tried contacting you by telephone today but was informed that you were out of the office.

I have today been informed that your investigation is now complete and that it has recently been that no criminal charges should be brought against Dr Barton. I should be grateful if you would confirm in writing, at your earliest possible convenience, that this is indeed the case.

As the statutory body responsible for regulating the medical profession, we are obviously concerned to learn of any doctor who is, or who has been, the subject of a criminal investigation. Whilst acknowledging the decision not to prosecute Code A before closing our file we must nevertheless satisfy ourselves that that there are no matters relating to her professional conduct or performance which may warrant formal action under the Council's fitness to practise procedures. I understand that you may be in possession of expert witness reports which are critical of the practices of both Dr Barton and a Dr Althea Lord.

In order to assist us in this regard I should be grateful if you would arrange for the following documentation to be forwarded to this office:

1. A brief case summary

2. Copies of witness statements

3. Copies of expert reports

178 Great Portland Street London W1W 5JE Telephone 020 7580 7642 Fax 020 7915 3641

4. Copies of relevant medical records, if available

We appreciate that when disclosing confidential information you need to balance the rights of privacy of the individual against a necessary need to protect the public.

For your information I am enclosing under cover of this letter a copy of the Medical Act 1983 (Amendment) Order 2000. In particular I would draw your attention to Section 35A of the Amendment Order which, in broad terms, gives the GMC the right to demand disclosure of information in certain circumstances where it is considered necessary for the purpose of assisting us to carry out our statutory regulatory role. I trust that on reviewing the legislation you will agree that, given both the nature of the original concerns about Code A practice and her public position, our request for information is be both reasonable and relevant.

It may also be helpful in this respect if I draw your attention to the comments of *Kennedy LJ* in the case *of Woolgar v Chief Constable of Sussex Police (2000) 1 WLR 25* where he stated:

> *Obviously in each case a balance has to be struck between competing public interests and at least arguably in some cases the reasonableness of the Police view may be opened to challenge. If they refuse to disclose, the regulatory body may, if aware of the existence of the information, make an appropriate Application to the Court."*

Should you have any further questions please do not hesitate to contact me. Thank you for your assistance in this matter. I look forward to hearing from you at your earliest possible convenience.

Yours sincerely

Code A

HAMPSHIRE Constabulary

Paul R. Kernaghan QPM LL.B MA DPM MCIPD
Chief Constable

Major Incident Complex
Kingston Crescent
North End
Portsmouth
PO2 8BU

Our Ref. : Code A
Your Ref. : 2000/2047

Tel. :
Direct Dial : Code A
Fax. :

14 February 2002

Code A
Fitness to Practise Directorate
General Medical Council
178 Great Portland Street
LONDON
W1W 5JE

Dear Code A

Re: Dr Jane BARTON

I am writing following your letter of the 7th February and our conversation of the 13th concerning the above named.

As I outlined to you the enquiry at Gosport War Memorial Hospital has generated a significant amount of documentation.

In the first instance, as agreed, I will arrange for you to be copied:

- Any statements/reports referred to in the LIVESLEY, FORD, MUNDY reports.
- Patient notes for any person referred to in the above reports.
- Any other obvious supporting documentation.

I will arrange for Code A to collate the papers. If you have any queries he can be contacted on Code A

HAMPSHIRE Constabulary

Should you, after receiving the first tranche of documents, identify further material you would like disclosed please contact Code A direct.

If I can be of any other assistance please advise.

Yours sincerely

Code A

J JAMES
Detective Superintendent

Portsmouth HealthCare NHS

NHS Trust

Department of Medicine for Elderly People
South Block
Queen Alexandra Hospital
Cosham
Portsmouth
PO6 3LY

Tel 023 9220 6000
Fax 023 9220 0381

FAX

Please telephone if any page is missing or indistinct.

TO: GENERAL MEDICAL COUNCIL DATE: 21/02/02

FOR THE ATTENTION OF: Code A FAX NO: Code A

FROM: **Department of Medicine for Elderly People**
Queen Alexandra Hospital
Cosham
PORTSMOUTH
PO6 3LY

NO. OF PAGES INCLUDING THIS SHEET: 2

TEL: Code A

CONFIDENTIAL

This fax may contain confidential information and you may not be the intended recipient, you must not copy or make any unauthorised disclosure of such information. If you have received this fax in error, please destroy the original and telephone Code A or Code A immediately.

MESSAGE:

I have been unable to contact Code A so far today re his letter to Dr. Barton but will be in contact in due course about this.

Regards

Code A

file Copy

Portsmouth HealthCare NHS
NHS Trust

Department of Medicine for Elderly People
Queen Alexandra Hospital
Cosham
Portsmouth
Hants
PO6 3LY

Tel 023 9228 6000
Fax 023 9220 0381

PRIVATE AND CONFIDENTIAL
Dr J A Barton
The Surgery
148 Forton Road
Gosport
Hants PO12 3HH

13 February 2002

RIR/cmp

Code A

Dear Dr Barton

Following our meeting I am writing to confirm what we agreed.

We agreed that you would cease to provide in patient care, both in and out of hours, for patients on Sultan Ward at Gosport War Memorial Hospital.

We agreed that you would continue to use Healthcall to cover your on call commitments in respect of your Practice's contract to provide out of hours cover to Daedalus and Dryad Wards.

We agreed that we would review this arrangement after there was clarity about your referral (or otherwise) to the Interim Orders Committee of the General Medical Council, or in one months time, which ever is sooner.

We also agreed to conduct a retrospective audit of your prescribing on Sultan Ward.

Thank you very much for your co-operation in this matter.

Yours sincerely

Code A ode A

HAMPSHIRE Constabulary

Paul R. Kernaghan QPM LL.B MA DPM MCIPD
Chief Constable

Major Incident Complex
Kingston Crescent
North End
Portsmouth
PO2 8BU

Our Ref. : MIC/Det.Supt/JJ/DM
Your Ref. :

Tel. :
Direct Dial : Code A
Fax. :

06 February 2002

Code A
Fitness to Practice Directorate
General Medical Council
178 Great Portland Street
LONDON
W1W 5JE

Dear Code A

Re: Dr Jane BARTON and Dr Anthea Everista Geredith LORD

I am writing following my letter to you of the 14th august 2001, concerning police investigations into patient deaths at Gosport War Memorial Hospital. You will note that this correspondence referred to preliminary police investigations to determine whether or not an intensive investigation of deaths at Gosport War Memorial Hospital was warranted.

In furtherance of those investigations expert reports were commissioned in respect of four other patient deaths and a further review of a particular death, Gladys RICHARDS in August 1998, which was previously subject of correspondence with the GMC. Receipt of the further reports was delayed for a number of reasons beyond our control.

However, they have now been reviewed and it has been determined that at this stage no further police investigations are appropriate. This decision is subject to review should further substantial evidence become available.

In reviewing the reports (which are enclosed) it is clear that the commentary and conclusions of the authors raise very serious concerns about the standard of clinical and nursing care delivered to the named patients at Gosport War Memorial Hospital. Specifically the care delivered by Dr BARTON is subject to particular criticism and raises concerns about her professional conduct. To a lesser extent there are implicit concerns about the professional conduct of Dr LORD as the consultant physician who had overall responsibility for patients on Daedulus and Dryad wards at Gosport War Memorial Hospital.

HAMPSHIRE Constabulary

It is my conclusion that the reports should be disclosed to you as the regulatory body for the named individuals for your action as appropriate. I should further advise that disclosure to you is for the purpose as described on the advice of our Force solicitor and disclosure to any third party should be referred back to us in the first instance.

If I can be of further assistance, please do not hesitate to contact me.

Yours sincerely

Code A

J JAMES
Detective Superintendent

Code A

POLICE STATEMENT OF Code A

1. I, am Dr Jane Barton of the Surgery, 148 Forton Road, Gosport Hampshire.

2. I am a Registered Medical Practitioner and qualified in 1972 at Oxford University with the degrees MA, BM BCh. I joined my present GP practice initially as an assistant and then as a partner. In 1988 I took up the additional post of Clinical Assistant in Elderly Medicine on a part time sessional basis. This post originally covered three sites but in due course was centred at Gosport War Memorial Hospital (GWMH). I retired from that position this year.

3. As a General Practitioner, I have a minimum full time position. I have approximately 1500 patients on my list. I conduct half of the on call responsibilities of my partners, with one night each fortnight on call and one weekend every quarter. I carry out one morning surgery every day and evening surgeries on a pro rata basis.

4. The GWMH has 48 long stay beds and is designed to provide continuing care for elderly patients. In each week I would carry out 5 Clinical Assistant sessions. When in this post I would attend the hospital every week day morning at an early hour to review patients and would conduct two formal ward rounds each week with the consultant geriatrician. At the time of my retirement from the post there were two consultants attending the wards. Dr Lord was the consultant responsible for Daedalus Ward. In August 1998, however only one consultant was in post; Dr Lord who was thus covering both wards. The other consultant was [redacted]

5. The consultant would ordinarily carry out two ward rounds each week; one continuing care and a Stroke round on Daedalus on a Thursday afternoon. Her other clinical commitments were on two other hospital sites, but she was usually available by telephone for advice and assistance

6. As Clinical Assistant, I was responsible for care of patients in both wards at the hospital. My work involved seeing a large number of elderly patients approaching the end of their lives and requiring continuing care from the Health Service. Many patients had undergone orthopaedic procedures following falls, whether in their own home, sheltered accommodation or

in residential care. They were transferred to our care once their acute management was completed. Many of the patients were also demented. I spent time attempting to forge a relationship with families and helping them to come to terms with the approaching death of a loved one. One of the strengths of our unit is that patients can be offered a level of freedom from pain, discomfort, unpleasant symptoms and mental distress which is much more difficult to deliver in an Acute Unit. One complication for our patients is that the act of transferring someone from one unit to another for whatever reason causes a marked deterioration in their condition, which may last for several days and is frequently irreversible.

7. In carrying out my work I relied on a team of nurses, both trained and untrained, to support the work that I did. Their attitude towards relatives and handing of the patients is crucial to the way the unit works. My work also involved providing support and guidance to my staff.

8. Mrs Gladys Richards was 91 and was admitted to the GWMH on 11.8.98. She had previously been a resident in the Glenheathers Nursing Home in Lee-on-the-Solent where she had fallen and fractured the neck of her right femur. She had been admitted to the Royal Hospital Haslar (RHH) and undergone a right hemi arthroplasty, a major orthopaedic procedure involving replacing the head of her femur with a metal prosthesis. The operation is performed to relieve pain and to give a patient a chance of walking again.

9. Following surgery she was assessed at RHH by Dr Ian Reid, Consultant Physician in Elderly Medicine at the Queen Alexandra Hospital, Portsmouth. Dr Reid provided an opinion to the Orthopaedic Consultant Surgeon at RHH, which gave some of the background information to Mrs Richards' condition. He reported that Mrs Richards had apparently been confused for some years, but was mobile in her nursing home until around Christmas 1997 when she had sustained a fall. She started to become increasingly noisy. She had been seen by Dr Banks a consultant Psycho geriatrician who appeared to have felt that she was depressed as well as suffering from a dementing illness. She had therefore been treated with haloperidol, a major tranquilliser and Trazodone, a sedating antidepressant.

10. Dr Reid reported that according to Mrs Richards' daughters she had been "knocked off" by this medication for months and had not spoken to them for some six to seven months. Her mobility had also deteriorated in that time and when unsupervised she had a tendency to get up and fall. Dr Reid understood that she was usually continent of urine but had occasional episodes of faecal incontinence. Dr Reid noted that following admission, Haloperidol and Trazodone had been stopped. According to the daughters, following the discontinuance of the Haloperidol and

Trazodone she appeared much brighter mentally and had been speaking to them at times. Dr Reid went on to say that when he had seen Mrs. Richards in hospital on 3rd August she had clearly been confused and was unable to give any coherent history. She was, however, pleasant and co-operative. She was able to move her left leg quite freely and, although not able actively to lift her extended right leg from the bed, she appeared to have little discomfort on passive movement of the right hip. Dr Reid was of the view that, despite her dementia, she should be given the opportunity to try to re-mobilise and it was his intention therefore to arrange transfer to the GWMH on Daedalus Ward under the care of his colleague Dr Lord in order to give her this opportunity.

11. The admission then took place to the GWMH on 11th August. The RHH would not have been able to keep Mrs Richards as an in patient, as her condition was not appropriate for an acute bed. Dr Reid had also recorded that Mrs Richards' daughters were unhappy with the care she had been receiving at the Nursing Home and that they did not wish her to return there. Her admission was therefore also a holding manoeuvre while it was seen whether she would recover and mobilise after the surgery. In this case she could be transferred back to a nursing home. If, as was more likely, she would deteriorate due to her age, her dementia, her frail condition and the shock of the fall followed by the major surgery, then she was to be nursed in a calm environment away from the stresses of an acute ward.

12. I assessed Mrs. Richard on admission. My admission note made on 11th August reads as follows:-

11.8.98 *Transferred to Daedalus Ward Continuing Care*
HPC Ⓡ # neck of femur 30.7.98
PMH) Hysterectomy 1955
Cataract operations
deaf
Altzheimers
0/E Impression frail hemi arthroplasty.
Not obviously in pain.
Please make comfortable.
transfers with hoist
usually continent
needs help with ADL
Barthel 2

I am happy for nursing staff to confirm death

13. In my view Mrs Richards was probably near to death, in terms of weeks and months from her dementia before the hip fracture supervened. Given her transfer from nursing home to acute hospital and then to continuing care and the fact that she had recently undergone major surgery; in addition to her general frailty and dementia, I appreciated that there was a possibility that she might die sooner rather than later. This explains my reference at that time to the confirmation of death, if necessary by the nursing staff.

14. The Barthel score is an assessment of general physical and life skill capability. The maximum score available would be 20, but Mrs Richards was so dependant that she scored only 2. She needed total care with washing and dressing, eating and drinking and was only mobile with 2 people and hoist for transfers to bed from chair etc..

15. When I assessed Mrs Richards on her arrival she was clearly confused and unable to give any history. She was pleasant and co-operative on arrival and did not appear to be in pain. Later her pain relief and sedation became a problem. She was screaming. This can be a symptom of dementia but could also be caused by pain. In my opinion it was caused by pain as it was not controlled by Haloperidol alone. Screaming caused by dementia is frequently controlled by this sedative. Given my assessment that she was in pain I wrote a prescription for a number of drugs on 11th August, including Oramorph and Diamorphine. This allowed nursing staff to respond to their clinical assessment of her needs, rather than wait until my next visit the following day. This is an integral part of team management. It was not in fact necessary to give Diamorphine over the first few days following her admission but a limited number of small doses of Oramorph were given totaling 20mg over the first 24 hours and 10 mg daily thereafter. This would be an appropriate level of pain relief after such a major orthopaedic procedure.

16. On the afternoon of 13th August Mrs Richards was found by nursing staff to have slipped out of her chair at approximately 1.30pm. I was not at the hospital or on duty at that time, and I was not made aware that day that she had injured herself. The duty doctor, Dr M. Brigg was contacted during the evening by nursing staff. He advised analgesia through the night and an X-Ray the following morning. The X-Ray Department at GWMH closes at 5.00pm and he felt that it was not appropriate to transfer and X-Ray the patient at RHH that evening. A transfer that evening would not have altered clinical management and it was left that I would review the patient in the morning. I arrived as usual early on the following morning 14th August and assessed Mrs. Richards. The report I received from the trained staff on duty that Friday morning

stated that she had slipped out of her chair the previous day. I arranged an X-Ray and discussed the position with the ward manager Philip Bede. The plan was that if the X-ray confirmed a dislocation of her prosthesis then Mrs Richards should be transferred to Haslar after confirmation with Dr Lord. The X-ray revealed that she had indeed dislocated her prosthesis. Code A Code A at the RHH was contacted and Mrs Richards was duly transferred back to the Haslar hospital. Although I was concerned, given Mrs Richard's overall condition and her frailty, that she might not be well enough for another surgical procedure; I felt that this clearly would be a matter for assessment by the clinicians at Haslar.

17. My notes on that occasion read as follows:-

"*14.8.98* *Sedation/pain relief has been a problem*
screaming not controlled by haloperidol
but very sensitive to Oramorph.
Fell out of chair last night
Ⓡ hip shortened and internally rotated
Daughter aware and not happy
Plan X-Ray
Is this lady well enough for another surgical procedure?"

18. I later made a further entry in Mrs Richards' records as follows:-

"*14.8.98* *Dear* Code A
Further to our telephone conversation
thank you for seeing this unfortunate
lady who slipped from her chair at
1.30 p.m. yesterday- and appears to have
dislocated her R hip
hemi arthroplasty was done on 30.7.98
I am sending X-Rays across
she has had 7.5 mls of 10 mg/ in 5 ml oramorph
at midday
Many thanks"

19. This is a copy of the courtesy referral letter I prepared to advise Code A Spalding of the position after telephoning him. Once at RHH. Mrs Richards had a closed

reduction of the prosthesis under intravenous anaesthesia. She remained unconscious and unresponsive for approximately 24 hours during which time she was catheterised. Normally a healthy patient would wake up within minutes of the end of an Intra-venous anaesthetic (a short acting agent is used). This worrying response to the anaesthetic may well have been an indication of how ill and frail she was.

20. On 17th August it was considered appropriate to transfer her back to the Daedalus Ward at GWMH. The discharge letter from RHH to the nurse in charge gave advice as to how she was to be nursed using a canvas knee immobilising splint to prevent crossing of the legs and further dislocation of the hip as this was a strong possibility. This splint was to remain in situ for four weeks. When in bed it was advised that the hips be kept apart using pillows or a wedge. again to reduce the chances of dislocation. Despite these instructions while she was in bed, she could be stood with 2 nurses and fully weight bear. This instruction was given because when possible it is important to keep elderly patients moving. The surgeon was making it clear that if her general condition did improve then standing her out of bed would pose no dangers for the stability of her prosthesis.

21. I saw Mrs Richards when she was readmitted on the 17th August and my note reads as follows:-

17.8.98 *readmission to Daedalus from RHH*
closed reduction under iv sedation
remained unresponsive for some hours
now appears peaceful
Plan continue haloperidol
only give oramorph if in severe pain
see Code A *again"*

22. At the time of her arrival back on the ward Mrs Richards appeared peaceful and not in severe pain. This was however an initial judgement made on an assessment shortly after her arrival on the ward. I was concerned that she should have opiates only if her pain became a problem, and I altered her drug chart accordingly. I was not aware at that time that she had been having intravenous morphine at RHH until shortly before her transfer. This would have explained why at this time she appeared to be peaceful and not in pain. Her general condition had deteriorated as a result of the further operative procedure and subsequent transfer. For a frail, elderly and demented person, this can have a profound effect on their chances of survival. My

note "see daughters again" indicated that I should explain the position to Mrs Richards' Code A and prepare them for what I believed was to come. In my experience, transfer of an elderly frail patient in such circumstances frequently causes a set back in their condition with a marked deterioration. It can be something from which the patient does not recover.

23. I believe Mrs Richards later experienced further pain as it was necessary for the nursing staff to give Oramorph on four occasions between 1300 on the 17th and 0500 on the 18th August. During that time I was telephoned by the nursing staff out of my contracted hours and informed that Mrs Richards was very uncomfortable and might have suffered a further dislocation. I asked for another X- Ray to be arranged. It transpired that it was not possible for the X-Ray to be carried out simply on the basis of a verbal order; accordingly another GP signed the relevant form and the duty Doctor from my practice viewed an X-Ray with the consultant reporting the film. As far as I am aware he did not see the patient or write in her notes. The X-Ray did not show any dislocation.

24. I then reviewed Mrs Richard early the following morning. My entry for the 18th August reads as follows:-

18.8.98 *Still in great pain*
nursing a problem
I suggest sc diamorphine/Haloperidol/
Midazolam
I will see daughters today
Please make comfortable"

25. To my mind having seen Mrs Richard originally when she had been admitted on the 11th August there was by this stage a marked deterioration. My assessment of Mrs Richards on this occasion confirmed my view reached on readmission the previous day that she was dying. She was barely responsive and was in a lot of pain. By this time she was not eating or drinking. When I examined Mrs Richards there was a lot of swelling and tenderness around the area of the prosthesis. There was no evidence of infection at that time, and it was my assessment that she had developed a haematoma or large collection of bruising around the area where the prosthesis had been lying while dislocated. This was in all probability the cause of Mrs Richards' significant pain and unfortunately a not uncommon sequel to a further manipulation required to reduce the dislocation. This complication would not have been amenable to any surgical

intervention and again further transfer of such a frail and unwell elderly lady was not in her best interests and was inappropriate.

26. After I had seen Mrs Richards that morning and following morning GP surgery, I then spoke with her daughters in the presence of Philip Bede the Ward Manager. I explained my concern to administer appropriate and effective pain relief and that without this nursing their mother was a significant problem. They understood, but did not like the idea that diamorphine was to be given. However I explained that it was the most appropriate drug. As their mother was not eating or drinking or able to swallow, subcutaneous infusion (a tiny needle implanted under the skin) of pain killers was the best way to control her pain and by titrating the dose over 24 hours frequent injections could be avoided. Both daughters reluctantly agreed to the use of a syringe driver. This drug, the dose used and this mode of administration are standard procedures for patients who are in great pain but who cannot safely take medicines by mouth.

27. I believe I would have mentioned fluids and explained that in my view they were not appropriate. I was aware that Mrs Richards was not taking food or water by mouth. It would have been dangerous to try to give her food or water by mouth as her poor conscious state meant that she might have choked. Mrs Richards would have had mouth care and sips of water to aid her comfort. In view of this the only alternative for further nutrition would have been to administer fluids intravenously or subcutaneously. We did not have the facilities to administer iv fluids, and accordingly to do that it would have been necessary to transfer her back to an acute unit. I did not feel that this was appropriate medically. She might well not have survived the journey let alone the process. Given my assessment that she was terminally ill, and that the actual administration of fluid would not affect that outcome, it would not have been in her best interests and could have caused her further pain and distress.

28. I believe I would have explained to the daughters that subcutaneous fluids were not appropriate. Their use would not have altered the outcome and there are several clinical studies showing this in terminally ill patients. Administration of subcutaneous fluids can cause significant tissuing of fluid and discomfort for the patient. There is a risk of oedema and infection and even tissue necrosis. If the kidneys are failing the additional fluids can overload the heart and precipitate heart failure. This would cause clinical distress and require unpleasant treatment. Given these potential complications and the fact that subcutaneous fluids would not have affected the outcome, again I did not consider it would be in Mrs Richards' best interests that subcutaneous fluids be given.

29. I also included in my discussion the opinion that Mrs Richards was likely to develop a chest infection due in part to her immobility despite regular turning by the nurses and partly due to the inadequate clearing of secretions. Antibiotics would not have been appropriate or indeed effective.

30. I said to the daughters that the prognosis was very poor and that she was not well enough for a further transfer to an acute unit. I was concerned in all the circumstances to provide an honest view.

31. When Mrs Richard was admitted to Daedalus Ward for the first time, I think it was suggested by her daughters and reported to me by nursing staff, that she might be sensitive to morphine, hence my mention of it in the clinical notes of 14.8.98. However I had seen no evidence of that when she had been given Oramorph earlier in her admission. In the first 18 hours following her transfer back from RHH she was not responding to a total of 45 mg of morphine orally in less than 24 hours. Therefore to ensure pain relief this would have to be increased. Diamorphine is a more potent analgesic than Morphine. In view of the need to increase the amount of pain relief (45mgs of Morphine in less than 24 hours having been clearly insufficient) and that Morphine (into which Diamorphine is broken down) has a relatively short half life, I consider that 40mgs of Diamorphine was appropriate for her pain relief. Mrs Richards would also have developed a tolerance to opiates through the previous administrations of Oramorph.

32. My use of Midazolam in the dose of 20 mg over 24 hours was as a muscle relaxant, to assist movement of Mrs Richards for nursing procedures in the hope that she could be as comfortable as possible. I felt it appropriate to prescribe an equivalence of Haloperidol to that which she had been having orally since her first admission.

33. I reviewed Mrs Richards' condition with the senior trained staff again on the morning of 19th August. From my assessment it was apparent that she had a 'rattly' chest and had developed bronchopneumonia. This would have been as a result of her frail condition and despite the fact that she was being turned regularly she was vulnerable to an infection developing. I did not make a note of this assessment but did prescribe hyoscine in the dose of 400 mcg and this was duly added to the syringe driver. Hyoscine is an antimuscarinic drug which is given to dry the bronchial secretions produced by the infection. This drug as with the others was reviewed and discussed daily as I visited the ward and assessed her overall condition. I am clear in my mind that there was no apparent depression of Mrs Richard's respiration. Had

there been any such depression, I would have reviewed the drug regime. As it was, Mrs Richards was apparently now out of pain and accordingly I considered the drug regime and the dose used to have been appropriate. In such circumstances, as I was not in position to attend continuously, it was necessary to have reliance on the nursing staff for reports on any problems arising. No further problems were related to me during this period. I saw Mrs Richards again on the morning of 20th August. There was no significant change in her overall condition.

34. I saw Mrs Richards again on the morning of 21st August. My note of that attendance reads as follows:-

21.8.98 *I think more peaceful*
needs hyoscine for rattly chest"

35. In my clinical opinion, by the 19th August Mrs Richards had developed bronchopneumonia. I do not believe that the dose of 40 mg of diamorphine administered over 24 hours had contributed to the development of the bronchopneumonia. It was an appropriate amount required to relieve her of her pain.

36. Sadly Mrs Richards died on 21st August, being pronounced dead at 9.20pm by one of the nursing staff. I gather that her daughters were with her when she died.

37. On the next working day, Monday , 24th of August, I discussed the case with the Coroner's Officer, a police officer at Cosham Police Station. I informed him that Mrs Richards had sustained a fractured neck of femur on the ~~13th August~~ 30th July and was subsequently operated on at RHH. I would have told him of the dislocation and the fact that she had returned to RHH and back to our care and had died on 21st August; in my view of bronchopneumonia. The Coroners Officer was happy that no further investigation was required and I signed the death certificate putting bronchopneumonia as the cause of death. I believe that this was the cause of death in all the circumstances.

38. At no time was any active treatment of Mrs Richards conducted with the aim of hastening her demise. My primary and only purpose in administering the Diamorphine was to relieve the pain which Mrs Richards was suffering. Diamorphine can in some circumstances have an incidental effect of hastening a demise but in this case I do not believe that it was causing respiratory depression and was given throughout at a relatively moderate dose.

39. Similarly it was not my intention to hasten Mrs Richard's death by omitting to provide treatment for example in the form of intravenous or subcutaneous fluids. By the 18th August it was clear to me that Mrs Richards was likely to die shortly. I believed that transfer to another hospital where she would be in a position to receive intravenous fluids was not in her best interests as it would have been too much of a strain and brought about a premature demise. There is clear evidence that the administration of intravenous or subcutaneous fluids would not have prolonged her life and faced with the complications which could arise such intervention was not in her best interests.

40. I explained the position to Mrs Richard's daughters, they did not appear to demur at the time and indeed at no time requested a second opinion.

MEDICO-LEGAL REPORT

Re: **Gladys Mabel RICHARDS**
Arthur "Brian" CUNNINGHAM
Alice WILKE
Robert WILSON
Eva PAGE

Prepared by:

Professor G A Ford, MA, FRCP
Consultant Physician, Freeman Hospital
Newcastle upon Tyne
Professor of Pharmacology of Old Age, University of Newcastle upon Tyne

For: **Hampshire Constabulary**

Date: **12th December 2001**

Contents

Introduction and Remit of the Report

8.1 I am Professor of Pharmacology of Old Age in the Wolfson Unit of Clinical Pharmacology at the University of Newcastle upon Tyne, and a Consultant Physician in Clinical Pharmacology at Freeman Hospital. I am a Doctor of Medicine and care for patients with acute medical problems, acute poisoning and stroke. I have trained and am accredited on the Specialist Register in Geriatric Medicine, Clinical Pharmacology and Therapeutics and General Internal Medicine. I provide medical advice and support to the Regional Drugs and Therapeutics Centre Regional National Poisons Information Service. I was previously clinical head of the Freeman Hospital Care of the Elderly Service and have headed the Freeman Hospital Stroke Service since 1993. I undertake research into the effects of drugs in older people. I am co-editor of the book 'Drugs and the Older Population' and in 2000 was awarded the William B Abrams award for outstanding contributions to Geriatric Clinical Pharmacology by the American Society of Clinical Pharmacology and Therapeutics. I am a Fellow of the Royal College of Physicians and have practised as a Consultant Physician for nine years.

8.2 I have been asked by Detective Superintendent John James of Hampshire Constabulary to examine the clinical notes of five patients (Gladys Mabel Richards, Arthur "Brian" Cunningham, Alice Wilkie, Robert Wilson, Eva Page) treated at the Gosport War Memorial Hospital and to apply my professional judgement to the following:

- The gamut of patient management and clinical practices exercised at the hospital
- Articulation of the leadership, roles, responsibilities and communication in respect of the clinicians involved
- The accuracy of diagnosis and prognosis including risk assessments
- An evaluation of drugs prescribed and the administration regimes
- The quality and sufficiency of the medical records
- The appropriateness and justification of the decisions that were made
- Comment on the recorded causes of death
- Articulate the duty of care issues and highlight any failures

1.3 I have prepared individual reports on each case and an additional report commenting on general aspects of care at Gosport War Hospital from a consideration of all five cases.

1.4 I have been provided with the following documents by Hampshire Constabulary, which I have reviewed in preparing this report:

- Comment on the recorded causes of death
- Letter DS J James dated 15th August 2001
- Terms of Reference document
- Hospital Medical Records of Gladys Richards, Brian Cunningham, Alice Wilkie, Robert Wilson and Eva Page
- Witness statements by Leslie France Lack, and Gillian MacKenzie
- Report of Professor Brian Livesley
- Transcripts of police interviews with Gosport War Memorial staff Dr Barton, Mr Beed, Ms Couchman, Ms Joice

- Transcript of police interviews with Royal Hospital Haslar staff Dr Reid and [redacted] Code A
- Transcript of interviews with patient transfer staff [redacted] Code A
- Transcript of police interviews with or statements from following medical and nursing staff: Dr Lord, [redacted] Code A

[redacted] Code A

Gladys Mabel RICHARDS

Course of Events

2.1 Gladys Richards was 91 years old when admitted as an emergency via the Accident & Emergency Department to Haslar Hospital on 29Th July 1998. She had fallen onto her right hip and developed pain. At this time she lived in a nursing home and was diagnosed as having dementia. She had experienced a number of falls in the previous 6 months and the admission notes comments "*quality of life has ↓↓ markedly last 6/12*". She was found to have a fracture of the right neck of femur. An entry in the medical notes by Surgeon Commander Malcom Pott, Consultant orthopaedic surgeon dated 30 July 1998 states '*After discussion with the patient's daughters in the event of this patient having a cardiac arrest she is NOT for cardiopulmonary resuscitation. However she is to be kept pain free, hydrated and nourished.*' Surgery (right hemiarthroplasty) was performed on 30 July 1998.

2.2 On 3rd August she was referred for a geriatric opinion and seen by Dr Reid, Consultant Physician in Geriatrics on 3rd August 1998. In his letter dated 5th August 1998 he notes she had been on treatment with haloperidol and trazadone and that her daughters thought she had been 'knocked off' by this medication for months, and had not spoken to then for 6-7 months. Her mobility had deteriorated. Her daughters commented to Dr Reid that she had spoken to them and had been brighter mentally since the trazadone had been omitted following admission. Dr Reid found Mrs Richards to be confused but pleasant and cooperative, unable to actively lift her right leg from the bed but appeared to have little discomfort on passive movement of the right hip. He commented '*I understand she has been sitting out in a chair and I think that despite her dementia, she should be afforded the opportunity to try to re-mobilise her.* He arranged for her transfer to Gosport War Memorial Hospital.

2.3 Following Dr Reid's entry in the notes on 3rd August two further entries are made in the medical notes by the on call house officer (Dr Coales?) on 8th August 1998. Dr Coales was asked to see Mrs Richards who was agitated on the ward. She had been given 2mg haloperidol and was asleep when first seen at 0045h. At 02130 hr a further entry records Mrs Richards was '*noisy and disturbing other patients n ward. Unable to reason with patient. Prescribed 25mg thioridazine'*. A transfer letter for Sergeant Curran, staff nurse to the Sister in Charge dated 10th August 1998 describes Mrs Richards status immediately prior to transfer and notes *'Is now fully weight bearing, walking with the aid of two nurses and a zimmer frame. Gladys needs total care with washing and dressing eating and drinking. Gladys is continent, when she becomes fidgety and agitated it means she wants the toilet. Occasionally incontinent at night, but usually wakes.*

2.4 On 11th August 1998 Mrs Richards was transferred to Daedalus ward. Dr Barton writes *in the medical notes "Impression frail demented lady, not obviously in pain, please make comfortable. Transfers with hoist, usually continent, needs help with ADL Barthel 2. I am happy for nursing staff to confirm death".* The summary admitting nursing notes record *"now fully weight bearing and walking with the aid of two nurses and a Zimmer frame"*. On 12th August the nursing notes record "*Haloperidol given at 2330 as woke from sleep. Very agitated, shaking and crying. Didn't settle for more than a few*

*minutes at a time. Did not seem to be in pain".*On 13th August nursing notes record "*found on floor at 1330h. Checked for injury none apparent at time. Hoisted into safer chair. 1930 pain Rt hip internally rotated, Dr Brigg contacted advised Xray am and analgesia during the night. Inappropriate to transfer for Xray this pm."*

2.5 On 14th August 1998 Dr Barton wrote '*sedation/pain relief has been a problem. Screaming not controlled by haloperidol 1g ? but very sensitive to Oramorph. Fell out of chair last night. R hip shorter and internally rotated, Daughter nurse and not happy. Plan Xray . Is this lady well enough for another surgical procedure?"* A further entry the same day states "*Dear Cdr Spalding, further to our telephone conversation thank you for seeing this unfortunate lady who slipped from her chair and appears to have dislocated her R hip. Hemiarthroplasty was done on 30-8-98. I am sending Xrays. She has had 2.5ml of 10mg/5ml oramoroph at midday. Many thanks".*

2.6 Following readmission to Haslar hospital Mrs Richards underwent manipulation of R hip under iv sedation (2 mg midazolam) at 1400h. At 2215h the same day she was not responding to verbal stimulation but observations of blood pressure, pulse, respiration and temperature were all in the normal range. A further entry on 17th August by Dr Hamlin (House Officer) states "*fit for discharge today (Gosport War Mem) To remain in straight knee splint for 4/52. For pillow between legs (abduction) at night.*" A transfer letter to the nurse in charge at Daedalus ward states "*Thank you for taking Mrs Richards back under your care... was decided to pass an indwelling catheter which still remains in situ. She has been given a canvas knee immobilising splint to discourage any further dislocation and this must stay in situ for 4 weeks. When in bed it is advisable to encourage abduction by using pillows or abduction wedge. She can however mobilise fully weight bearing".*

2.7 Nursing notes record on 17th August " 1148h *returned from R.N.Haslar patient very distressed appears to be in pain. No canvas under patient – transferred on sheet by crew."* Later that day at 1305h "*in pain and distress, agreed with daughter to give her mother Oramorph 2.5mg in 5ml*". A further hip Xray was performed which demonstrated no fracture. Dr Barton writes on 17th August 1998 *"readmission to Daedalus ward. Closed reduction under iv sedation. Remained unresponsive for some hours. Now appears peaceful. Can continue haloperidol, only for Oramorph if in severe pain. See daughter again"* and on 18th August "*still in great pain, nursing a problem, I suggest sc diamorphine/ haloperidol/midazolam. I will see daughters today. Please make comfortable".* Nursing notes record "*reviewed by Dr Barton for pain control via syringe driver".* At 2000h "*patient remained peaceful and sleeping. Reacted to pain when being moved – this was pain in both legs".* On 19th August the nursing notes record "*Mrs Richards comfortable*" and in a separate entry "*apparently pain free*". There are no nursing entries I can find on 20th August. I can find no entries in the nursing notes describing fluid or food intake following admission on 17th August.

2.8 The next entry in the medical notes is on 21st August by Dr Barton "*much more peaceful. Needs hyoscine for rattly chest*". The nursing notes record "*patient's overall condition deteriorating. Medication keeping her comfortable*". A staff

nurse records Code A 's death in the notes at 2120h Code A The cause of death was recorded as bronchopneumonia.

2.9 Medication charts record the following administration of opiate, analgesic and sedative drugs during Code A s first admission to Haslar Hospital.

29 July 2000h Trazadone 100mg (then discontinued)
29 July to 11th August. Haloperidol 1mg twice daily
30 July 0230h Morphine iv 2.5mg
31 July 0150h morphine iv 2.5mg
1905h morphine iv 2.5 mg
1 Aug 1920h morphine iv 2.5mg
2 Aug 0720h morphine iv 2.5mg
Cocodamol two tablets as required taken on 16 occasions at varying times between 1-9th August

2.10 Medication charts record the following administration of opiate, analgesic and sedative drugs during Code A second admission to Haslar Hospital

14 Aug 1410h midazolam 2mg iv
15 Aug 0325h cocodamol two tablets orally
16 Aug 0410h haloperidol 2mg orally
0800h haloperidol 1mg orally
1800h haloperidol 1mg orally
2310h haloperidol 2mg orally
!7 Aug 0800h haloperidol 1mg orally

2.11 Medication charts record the following administration of opiate and sedative drugs on Daedalus ward:

11 Aug	1115h	5mg/5ml Oramorph
	1145h	10 mg Oramorph
	1800h	1 mg haloperidol
12 Aug	0615h	10 mg Oramorph
		haloperidol
13 Aug	2050h	10mg Oramorph
14 Aug	1150h	10mg Oramorph
17 Aug	1300h	5mg Oramorph
	?	5 mg Oramorph
	1645h	5mg Oramorph
	2030h	10mg Oramorph
18 Aug	0230h	10mg Oramorph
	?	10mg Oramorph
	1145h	diamorphine 40mg/24hr, haloperidol 5mg/24hr midazolam 20mg/24hrby
19 Aug	1120h	diamorphine 40mg/24hr, haloperidol 5mg/24hr midazolam 20mg/24hr, hyoscine 400microg/24hr
20 Aug	1045h	diamorphine 40mg/24hr, haloperidol 5mg/24hr midazolam 20mg/24hr, hyoscine 400microg/24hr
21 Aug	1155h	diamorphine 40mg/24h, haloperidol 5mg/24hr midazolam 20mg/24hr, hyoscine 400microg/24hr

Opinion on patient management

Leadership, roles, responsibilities and communication in respect of the clinicians involved

2.12 Primary responsibility for the medical care of Mrs Richards during her two admissions to Gosport Hospital lay with Dr Lord, as the consultant responsible for his care. My understanding is that day-to-day medical care was delegated to the clinical assistant Dr Barton and during out of hours period the on call doctor based at the Queen Alexander Hospital (statement of Dr Lord in interview with DC Colvin and DC McNally). Primary responsibility for the medical care of Mrs Richards during her two admissions to Queen Alexandra Hospital lay with Code A, Consultant Orthopaedic Surgeon. Junior medical staff were responsible for day-to-day medical care of Mrs Richards whilst at Queen Alexandra Hospital. Ward nursing staff were responsible for assessing and monitoring Mrs Richards and informing medical staff of any significant deterioration.

2.13 Dr Reid, Consultant Geriatrician was responsible for assessing Mrs Richards and making recommendations concerning her future care following her orthopaedic surgery, and arranged transfer to Gosport Hospital for rehabilitation.

Accuracy of diagnosis and prognosis including risk assessments

2.14 The initial assessment by the orthopaedic team was in my opinion competent and the admitting medical team obtained a good history of her decline in the previous six months. Surgeon Commander Code A discussed management options with the family and a decision was made to proceed with surgery but for Mrs Richards to not undergo cardiopulmonary resuscitation if she sustained a cardiac arrest, with a clear decision to keep Mrs Richards pain free, hydrated and nourished. There are good reasons to offer surgery for a fractured neck of femur to very frail patients with dementia even when a high risk of peri-operative death or complications is present. This is because without surgery patients continue to be in pain, remain immobile and nearly invariably develop serious complications such as pneumonia and pressure sores, which are usually fatal. From the information I have seen I would, as a consultant physician/geriatrician recommended the initial management undertaken. I consider it good management that the trazadone as discontinued when the history from the daughters suggested this might have been responsible for decline in the recent past.

2.15 After Mrs Richards was stable a few days following surgery it was appropriate to refer her for a geriatric opinion, and Dr Reid rapidly provided this. Dr Reid's assessment was in my opinion thorough and competent. He identified the potential for her to benefit from rehabilitation. I would consider his decision to refer her for rehabilitation despite her dementia to be appropriate. An elderly care rehabilitation, rather than an acute orthopaedic ward is in general a preferable environment to undertake such rehabilitation. It is implicit in his decision to transfer her to Gosport War Memorial Hospital that she would receive rehabilitation there and not care on a continuing care ward without input from a rehabilitation team. Dr Lord in an interview with DC McNally and DC Colvin describes Daedalus ward as "*Back in '98 .. Daedalus was a continuing care ward with 24 beds of which 8 beds were for slow stream stroke*

rehabilitation". Although Mrs Richards had a fractured neck of femur and not stroke as her primary problem requiring rehabilitation I would assume, in the light of Dr Reid's letter that she was transferred to one of the 8 slow stream rehabilitation beds on Daedalus ward.

2.16 The transfer letter from Sergeant Curran provides a clear description of Mrs Richards's status at the time of transfer. The observation that she was walking with the aid of two nurses and a zimmer frame, and the usual cause of agitation was when she needed to use the toilet are relevant to subsequent events following transfer to Gosport Hospital. The use of a Barthel Index score as a measure of disability is good practice and demonstrates that Mrs Richards was severely dependent at the time of her transfer to Gosport Hospital.

2.17 The initial entry by Dr Barton following Mrs Richards' transfer to Daedalus ward does not mention that she has been transferred for rehabilitation, and focuses on keeping her 'comfortable' despite recording that she is "*not obviously in pain".* The statement '*I am happy for nursing staff to confirm death*" also suggests that Dr Barton's assessment was that Mrs Richards might die in the near future. Dr Barton in her statement to DS Sackman and DC Colvin, confirms this when she states "*I appreciated that there was a possibility that she might die sooner rather than later*". Dr Barton refers to her admission as a "*holding manoeuvre*" and her statement suggests a much more negative view of the potential for rehabilitation. She does not describe any rehabilitation team or focus on the ward and suggests her transfer was necessary because she was not appropriate for an acute bed, rather than her being appropriate for rehabilitation- "*.her condition was not appropriate for an acute bed. ....seen whether she would recover and mobilise after surgery. If as was more likely she would deteriorate due to her age, her dementia, her frail condition and the shock of the fall followed by the major surgery, then she was to be nursed in a clam environment away from the stresses of an acute ward*". In my opinion this initial note entry and the statement by Dr Baron indicate a much less proactive view of rehabilitation, less appreciation than Dr Reid of the potential for Mrs Richards to recover to her previous level of functioning, and probably a failure to appreciate the potential benefits of appropriate multidisciplinary rehabilitation to Mrs Richards. This leads me to believe that Dr Barton's approach to Mrs Richards was in the context of considering her as a continuing care patient who was likely to die on the ward. It was not wrong or incorrect of Dr Barton to believe Mrs Richards might die on the ward, but I would consider her apparent failure to recognise Mrs Barton's rehabilitation needs may have led to subsequent sub-optimal care.

2.18 There are a number of explanations and contributory factors that may have led to Dr Barton possibly not recognising Mrs Richard's rehabilitation needs in addition to her nursing and analgesic needs. First she may have not clearly understood Dr Reid's assessment that she needed rehabilitation. In her statement Dr Barton states " *Dr Reid was of the view that, despite her dementia, she should be given the opportunity to try to remobilise*" which suggests Dr Barton may not have considered the necessity for Mrs Richards to receive Physiotherapy as a necessary part of her opportunity to remobilise. Second the ward had both continuing care and rehabilitation beds and these patients may require very different care. It is not uncommon for "slow stream" rehabilitation beds to be in the same ward as continuing care beds, but it does

require much broader range of care to meet the medical and social needs of these patients. I would anticipate that some patients would move from the slow stream rehabilitation to continuing care category. Dr Lord describes the existence of fortnightly multidisciplinary ward case conference suggesting there was a structured team approach that would have made Dr Barton and nursing staff aware of rehabilitation needs of patients. In Mrs Richards's case no such case conference took place because she became too unwell in a short period. Third Dr Barton may not have received sufficient training or gained adequate experience of rehabilitation or geriatrics despite working under the supervision of Dr Lord. Dr Lord states that Dr Barton was "*an experienced GP*" who had rights of admission to a GP ward and that Dr Lord had admitted patients "*under her care say for palliative care*". Experience in palliative care may possibly have influenced her understanding and expectations of rehabilitating older patients.

2.19 The assessment of Mrs Richard's agitation the following day on 12th August was in my opinion sub-optimal. The nursing records state that she did not appear to be in pain. There is no entry from Dr Barton this day but in her statement she states which I have some difficulty in interpreting: "*When I assessed Mrs Richards on her arrival she was clearly confused and unable to give any history. She was pleasant and co-operative on arrival and did not appear to be in pain. Later her pain relief and sedation became a problem. She was screaming. This can be a symptom of dementia but could also be caused by pain. In my opinion it was caused by pain as it was not controlled by Haloperidol alone. Screaming caused by dementia is frequently controlled by this sedative. Given my assessment that she was in pain I wrote a prescription for a number of drugs on 11th August, including Oramorph and Diamorphine. This allowed nursing staff to respond to their clinical assessment of her needs rather than wait until my next visit the following day. This is an integral part of team management. It was not in fact necessary to give diamorphine over the first few days following her admission but a limited number of small doses of Oramorph were given totalling 20mg over the first 24 hours and 10mg daily thereafter. This would be an appropriate level of pain relief after such a major orthopaedic procedure*".

2.20 I am unable establish from the notes and Dr Barton's statement whether she saw Mrs Richards in pain after she wrote in the notes and then wrote up the opiate drugs later on the 11th August, or if she wrote up these drugs after seeing her when she was not in pain, because she considered she might develop pain and agitation. In either case there is no evidence that the previous information provided by Code A that Mrs Richards usually required the toilet when she was agitated was considered by Dr Barton. Screaming is a well-described behavioural disturbance in dementia (Dr Barton was clearly aware of this), which can be due to pain but is often not. In some cases it is not possible to identify a clear precipitating cause although a move to a new ward could precipitate such a behavioural disturbance. I would consider the assumption by Dr Barton that Mrs Richards screaming was due to pain was not supported by her own recorded observations. There is no evidence from the notes that Dr Barton examined Mrs Richards in the first two days to find any evidence on clinical examination that pain from her hip was the cause of her screaming. If the screaming had been worse on weight bearing or movement of the hip this would have provided supportive evidence that her screaming was

due to hip pain. Staff Nurse Jennifer Brewer in her interview with DC Colvin and DC McNally states that the nursing staff had considered the need for toileting and other potential causes of Mrs Richards screaming.

2.21 Mrs Richards pain following surgery had been controlled at Haslar hospital by intermittent doses of intravenous morphine and then intermittent doses of cocodamol (paracetamol and codeine phosphate). Dr Barton did not prescribe cocodamol or another mild or moderate analgesic to Mrs Richards to take on a prn basis when she was transferred. This makes me consider it probable that Dr Barton prescribed prn Oramorph, diamorphine, hyoscine and midazolam when she first saw Mrs Richards and she was not in pain. If this is the case it is highly unusual practice in a patient who has been transferred for rehabilitation, was not taking any regular or intermittent analgesics for 36 hours prior to transfer, and had last taken two tablets of cocodamol. In a rehabilitation or continuing care ward without resident medical staff I would consider it reasonable and usual practice to prescribe a mild or moderate analgesic to take on an as required basis in case further pain developed. In Mrs Richards's case a reasonable choice would have been cocodamol since she had been taking this a few days earlier without problems. I do not consider it was appropriate to administer intermittent doses of oramorph to Mrs Richards before first prescribing paracetamol, non-steroidal anti-inflammatory drugs or mild opiate. It is not appropriate to prescribe powerful opiate drugs as a first line treatment for pain not clearly due to a fracture or dislocation to a patient such as Mrs Richards 12 days following surgery. Dr Barton's statement that diamorphine and oramorph were appropriate analgesics at this stage following surgery when she had been pain free is incorrect and in my opinion would not be a view held by the vast majority of practising general practitioners and geriatricians.

2.22 The management of Mrs Richards when sustained a dislocation of her hip on 13th August was in my opinion sub-optimal. The hip dislocation most likely occurred following the fall from her chair at 1330h. The nursing notes suggest signs of a dislocation were noted at 1930h. If there was a delay in recognising the dislocation I would not consider this indicates poor care, as hip fractures and dislocations can be difficult to detect in patients who have dementia and communication difficulties. Mrs Richards suspected dislocation or fracture was discussed with the on-call doctor, Dr Briggs, who I would assume is a medical house officer. Given the concern about a fracture or dislocation I would judge it would have been preferable for her to b transferred to the orthopaedic ward that evening and be assessed by the orthopaedic team. I certainly consider the case should have been discussed with either the on call consultant geriatrician or the orthopaedic team. The benefits of transfer that evening in a patient where it was highly probable a fracture or dislocation were present would have been Mrs Richards could have received manipulation earlier the following morning and possibly that same evening, and that traction could have been applied even if reduction was not attempted.

2.23 Mrs Richards was found to have a dislocation of her right hip and this was manipulated under intravenous sedation the same day. Although she was initially unresponsive, most probably due to prolonged effects of the intravenous midazolam, 3 days later on 17th August she was mobilising and fully weight bearing and not requiring any analgesia. Although there are few medical note entries, the management at Haslar hospital during this period

appears to be appropriate and competent. Shortly after transfer back to Daedalus ward Mrs Richards again became very distressed. The nursing notes indicate there was an incorrect transfer by the ambulance staff of Mrs Richards onto her bed. Repeat dislocation of the right hip was reasonably suspected but not found on a repeat Xray. My impression is that this transfer may have precipitated hip or other musculoskeletal pain in Mrs Richards but that other causes of screaming were possible.

2.24 Intermittent doses of oral morphine were first administered to Mrs Richards, again without first determining whether less powerful analgesics would have been helpful. On 18th August Dr Barton suggested commencing subcutaneous diamorphine, haloperidol and midazolam. The diamorphine and midazolam had been prescribed 7 days earlier. An infusion of the three drugs was commenced later that morning and hyoscine was added on 19th August. Both Dr Barton's notes and the nursing notes indicate Mrs Richards was in pain, although it is not clear what they considered was the cause of the pain at this stage, having excluded a fracture or dislocation of the right hip. Dr Barton states in her prepared statement "... *it was my assessment that she had developed a haematoma or large collection of bruising around the area where the prosthesis had been lying while dislocated*".

2.25 Although there are no clear descriptions of Mrs Richard's conscious level in the last few days, her level of alertness appears to have deteriorated once the subcutaneous infusion of diamorphine, haloperidol and midazolam was commenced. It also seems that she was not offered fluids or food and intravenous or subcutaneous fluids were not considered as an alternative. My interpretation is that this was most probably because medical and nursing staff were of the opinion that Mrs Richards were dying and that provision of fluids or nutrition would not change this outcome. In her prepared statement Dr Barton states "*As their mother was not eating or drinking or able to swallow, subcutaneous infusion of pain killers was the best way to control her pain.*" and "*I was aware that Mrs Richards was not taking food or water by mouth*". She then goes on to say "*I believe I would have explained to the daughters that subcutaneous fluids were not appropriate*".

Evaluation of drugs prescribed and the administration regimens

2.26 The decision to prescribe oral opiates and subcutaneous diamorphine to Mrs Richards initial admission to Daedalus ward was in my opinion inappropriate and placed Mrs Richards at significant risk of developing adverse effects of excessive sedation and respiratory depression. The prescription of oral paracetamol, mild opiates such as codeine or non-steroidal anti-inflammatory drugs such as ibuprofen, naproxen would have been appropriate oral and preferable with a better risk/benefit ratio. The prescription of subcutaneous diamorphine, haloperidol and midazolam infusions to be taken if required was inappropriate even if she was experiencing pain. Subcutaneous opiate infusions should be used only in patients whose pain is not controlled by oral analgesia and who cannot swallow oral opiates. The prescription by Dr Barton on 11th August of three sedative drugs by subcutaneous infusion was in my opinion reckless and inappropriate and placed Mrs Richards at serious risk of developing coma and respiratory depression had these been administered by the nursing staff. It is exceptionally unusual to prescribe subcutaneous infusion of these three drugs with powerful effects on conscious level and respiration to

frail elderly patients with non-malignant conditions in a continuing care or slow stream rehabilitation ward and I have not personally used, seen or heard of this practice in other care of the elderly rehabilitation or continuing care wards. The prescription of three sedative drugs is potentially hazardous in any patient but particularly so in a frail older patient with dementia and would be expected to carry a high risk of producing respiratory depression or coma.

2.27 I consider the statement by Dr Barton "*my use of midazolam in the dose of 20mg over 24 hours was as a muscle relaxant, to assist movement of Mrs Richards for nursing procedures in the hope that she could be as comfortable as possible. I felt it appropriate to prescribe an equivalence of haloperidol to that which she had been having orally since her first admission.*" Indicates poor knowledge of the indications for and appropriate use of midazolam administered by subcutaneous infusion to older people. Midazolam is primarily used for sedation and is not licensed for use as a muscle relaxant. Doses of benzodiazepine that produce significant muscle relaxation in general produce unacceptable depression of conscious level, and it is not usual practice amongst continuing care and rehabilitation wards to administer subcutaneous midazolam to assist moving patients.

Quality and sufficiency of the medical records

2.28 The medical and nursing records relating to Mrs Richards admissions to Daedalus ward are in my opinion not of an adequate standard. The medical notes fail to adequately account for the reasons why oramorph and then infusions of diamorphine and haloperidol were used. The nursing records do not adequately document hydration and nutritional needs of Mrs Richards during her admissions to Daedalus ward.

Appropriateness and justification of the decisions that were made

2.29 There are a number of decisions made in the care of Mrs Richards that I consider to be inappropriate. The initial management of her dislocated hip prosthesis was sub-optimal. The decision to prescribe oral morphine without first observing the response to milder opiate or other analgesic drugs was inappropriate. The decision to prescribe diamorphine, haloperidol and midazolam by subcutaneous infusion was, in my opinion, highly inappropriate.

Recorded cause of death

2.30 The recorded cause of death was bronchopneumonia. I understand that the cause of death was discussed with the coroner. A post mortem was not obtained and the recorded cause was certainly a possible cause of Mrs Richards's death. I am surprised the death certificate makes no mention of Mrs Richards's fractured neck of femur or her dementia. It is possible that Mrs Richards died from drug induced respiratory depression without bronchopneumonia present or from the combined effects of bronchopneumonia and drug-induced respiratory depression. Mrs Richards was at high risk of developing pneumonia because of the immobility that resulted following her transfer back to Daedalus ward even if she had not received sedative and opiate drugs. Bronchopneumonia can also occur as a secondary complication of opiate and sedative induced respiratory depression. In the absence of post-mortem, radiological data (chest Xray) or recordings of Mr Cunningham's respiratory rate I would consider the recorded cause of death of bronchopneumonia was possible. However given the rapid decline in

conscious level that preceded the development of respiratory symptoms (rattly chest) I would consider it more likely that Mrs Richards became unconscious because of the sedative and opiate drugs she received by subcutaneous infusion, that these drugs caused respiratory depression and that Mrs Richards died from drug induced respiratory depression and/or without bronchopneumonia resulting from immobility or drug induced respiratory depression. There are no accurate records of Mrs Richards respiratory rate but with the doses used and her previous marked sedative response to intravenous midazolam it is highly probable that respiratory depression was present.

Duty of care issues

2.31 Medical and nursing staff on Daedalus ward had a duty of care to deliver medical and nursing care to attempt to monitor Mrs Richards and to document the effects of drugs prescribed. In my opinion this duty of care was not adequately met. The prescription of diamorphine, midazolam and haloperidol was extremely hazardous and Mrs Richards was inadequately monitored. The duty of care of the medical and nursing staff to meet Mrs Richard's hydration and nutritional needs was also in my opinion probably not met.

Summary

2.32 Gladys Richards was a frail older lady with dementia who sustained a fractured neck of femur, successfully surgically treated with a hemiarthroplasty, and then complicated by dislocation. During her two admissions to Daedalus ward there was inappropriate prescribing of opiates and sedative drugs by Dr Baron. These drugs in combination are highly likely to have produced respiratory depression and/or the development of bronchopneumonia that led to her death. In my opinion it is likely the administration of the drugs hastened her death. There is some evidence that Mrs Richards was in pain during the three days prior to her heath and the administration of opiates can be justified on these grounds. However Mrs Richards was at high risk of developing pneumonia and it possible she would have died from pneumonia even if she had not been administered the subcutaneous sedative and opiate drugs.

Code A

Course of Events

3.1 Mr Cunningham was 79 years old when admitted to Dryad ward, Gosport Hospital under the care of Dr Lord. Dr Lord had assessed him on a number of occasions in the previous 4 years. A letter dated 2nd December 1994 from Code A Code A indicates Parkinson's disease had been diagnosed in the mid 1980s and that he was having difficulties walking at this time. In 1998 it was noted he had experienced visual hallucinations and had moved into Merlin Park Rest Home. His weight was 69Kg in August 1998. In July 1998 he was admitted under the care of Code A in Old Age Psychiatry to Mulberry Ward A and discharged after 6 weeks to Thalassa Nursing Home. He was assessed to have Parkinson's disease and dementia, depression and myelodysplasia. Dr Lord in a letter dated 1 September 1998 summarises her assessment of Mr Cunningham when she saw him on Mulberry Ward A on 27 August 1998 before he was discharged to Thalassa Nursing Home. At this time he required 1-2 people to transfer and was unable to wheel himself around in his wheelchair. She commented that more levodopa might be required but was concerned it would upset his mental state. She arranged to review him at the Dolphin Day Hospital.

3.2 On 21st September 1998 he was seen at the Dolphin Day Hospital by Dr Lord who recorded *'very frail, tablets found in mouth, offensive large necrotic sacral sore with thick black scar. PD - no worse. Diagnoses listed as sacral sore (in N/H), PD, old back injury, depression and element of dementia, diabetes mellitus –diet, catheterised for retention. Plan – stop codanthramer and metronidazole. looks fine. TCI Dyad today –aserbine for sacral ulcer – nurse on side – high protein diet – oramorph prn if pain. N/Home to keep bed open for next 3/52 at least. Pt informed of admission agrees. Inform N/Home* Code A Code A *and social worker. Analgesics prn.'* He was admitted to Dyad ward. An entry by Dr Baron on 21 September states *'make comfortable, give adequate analgesia. Am happy for nursing staff to confirm death'.* On 24th September Dr Lord has written *'remains unwell.* Code A *has ??? again today and is aware of how unwell he is. sc analgesia is controlling pain just. I am happy for nursing staff to confirm death.'* The next entry by Dr Brook is on 25th September *'remains very poorly. On syringe driver. For TLC'.*

3.3 Medication charts record the following administration of opiate and sedative drugs:

21 Sep 1415h Oramorph 5mg
1800h Coproxamol two tablets
(subsequent regular doses not administered)
2015h Oramorph10mg
21 Sep 2310h Diamorphine 20mg/24hr, midazolam 20mg/24hr infusion sc
22 Sep 2020h Diamorphine 20mg/24hr, midazolam 20mg/24hr infusion sc
23 Sep 0925h Diamorphine 20mg/24hr, hyoscine 200microg/24hr
midazolam 20 mg/24hr infusion sc
2000h Diamorphine 20mg/24hr, hyoscine 200microg/24hr
midazolam 60mg/24hr infusion sc
24 Sep 1055h Diamorphine 20mg/24hr, hyoscine 800microg/24hr
midazolam 80mg/24hr infusion sc
25 Sep 1015h Diamorphine 60mg/24hr, hyoscine 1200mg/24hr

midazolam 80mg/24hr infusion
26 Sep1150h Diamorphine 80mg/24hr, hyoscine 1200mg/24hr
midazolam 100mg/24hr infusion
Sinemet 110 5 times/day was discontinued on 23rd September

3.4 The nursing notes relating to the admission to Dyad ward record on 21st Sept *'remained agitated until approx 2030h. Syringe driver commenced as requested* (unclear who made this request) *diamorphine 20mg, midazolam 20mg at 2300. Peaceful following".* On 22nd Sep *'explained that a syringe driver contains diamorphine and midazolam was commenced yesterday evening for pain relief and to allay his anxiety following an episode where Arthur tried to wipe sputum on a nurse saying he had HIV and going to give it to her. He also tried to remove his catheter and empty the bag and removed his sacral dressing throwing it across the room. Finally he took off his covers and exposed himself.'*

3.5 On 23rd Sep *'Has become chesty overnight to have hyoscine added to driver. Stepson contacted and informed of deterioration. Mr Farthing asked is this was due to the commencement of the syringe driver and informed that Mr Cunningham was on a small dosage which he needed.'* A later entry *'now fully aware that Brian is dying and needs to be made comfortable. Became a little agitated at 2300h, syringe driver adjusted with effect. Seems in some discomfort when moved, driver boosted prior to position change'.* On 24th Sept *'report from night staff that Brian was in pain when attended to, also in pain with day staff – especially his knees. Syringe driver renewed at 1055".* On 25th Sept *'All care given this am. Driver recharged at 1015 –diamorphine 60mg, midazolam 80mg and hyoscine 1200mcg at a rate of 50mmols/hr. Peaceful night - unchanged, still doesn't like being moved.'* On 26th September *'condition appears to be deteriorating slowly'.*

3.6 On 26th September staff nurse Tubbritt records death at 2315h. Cause of death was recorded on the death certificate as bronchopneumonia with contributory causes of Parkinson's disease and Sacral Ulcer.

Opinion on patient management

Leadership, roles, responsibilities and communication in respect of the clinicians involved

3.7 Primary responsibility for the medical care of Mr Cunningham during his last admission lay with Dr Lord, as the consultant responsible for his care. She saw Mr Cunningham 5 days before his death in the Dolphin Day Hospital, and 2 days before his death on Dyad ward. My understanding is that day-to-day medical care was the responsibility of the clinical assistant Dr Barton and during out of hours period the on call doctor based at the Queen Alexander Hospital. Ward nursing staff were responsible for assessing and monitoring Mr Cunningham and informing medical staff of any significant deterioration.

Accuracy of diagnosis and prognosis including risk assessments

3.8 Initial assessment by Dr Lord was comprehensive and appropriate with a clear management plan described. The nursing staff record Mr Cunningham was agitated following admission on 21st September. Dr Lord had prescribed prn (intermittent as required) oramorph for pain. Nursing staff made the decision to administer oramorph but there is no clear recording in the nursing notes that he

was in pain or the site of pain. The nursing entry on 22nd Sept indicates a syringe driver was commenced for 'pain relief and to allay anxiety. Again the site of pain is not states. My interpretation of the records is that the nursing staff considered his agitation was due to pain from his sacral ulcer. The medical and nursing teams view on the cause of Mr Cunningham's deterioration on 23rd September when he became 'chesty' are not explicitly stated, but would seem to have been thought to be due to bronchopneumonia since this was the cause of death later entered on the death certificate. The medical and nursing staff may not have considered the possibility that Mr Cunningham's respiratory symptoms and deterioration may have been due to opiate and benzodiazepine induced respiratory depression. The nursing staff filed to appreciate that the agitation Mr Cunningham experienced on 23rd Sept at 2300h may have been due to the midazolam and diamorphine. It was appropriate for nursing staff to discuss Mr Cunningham's condition with medical staff at this stage.

3.9 When Dr Lord reviewed Mr Cunningham on 24th September the notes imply that he was much worse that when she had seen him 3 days earlier. There is clear recording by Dr Lord that Mr Cunningham was in pain. The following day the diamorphine dose was increased three fold from 20mg/24hr to 60mg/24hr and the dose was further increased on 26th September to 80mg/24hr although the nursing and medical notes do not record the reason for this. The notes suggest that the nursing and medical staff may have failed to consider causes of agitation other than pain in Mr Cunningham or to recognise the adverse consequences of opiates and sedative drugs on respiratory function in frail older individuals.

Evaluation of drugs prescribed and the administration regimens

3.10 The prescription of oramorph to be taken 4 hourly as required by Mr Cunningham was reasonable if his pain was uncontrolled from cocodamol. I consider the decision by Dr Barton to prescribe and administer diamorphine and midazolam by subcutaneous infusion the same evening he was admitted was highly inappropriate, particularly when there was a clear instruction by Dr Lord that he should be prescribed intermittent (underlined instruction) doses of oramorph earlier in the day. I consider the undated prescription by Dr Baron of subcutaneous diamorphine 20-200mg/24hr prn, hyoscine 200-800microg/24hr and midazolam 20-80mg/24hr to be poor practice and potentially very hazardous. In my opinion it is poor management to initially commence both diamorphine and midazolam in a frail elderly underweight patient such as Mr Cunningham. The combination could result in profound respiratory depression and it would have been more appropriate to review the response to diamorphine alone before commencing midazolam, had it been appropriate to commence subcutaneous analgesia, which as I have stated before was not the case.

3.11 In my opinion it is doubtful the nursing and medical staff understood that when a syringe infusion pump rate is increased it takes an often appreciable effect of time before the maximum effect of the increased dose rate becomes evident. Typically the time period would be 5 drug half-lives. In the case of diamorphine this would be between 15 and 25 hours in an older frail individual.

Quality and sufficiency of the medical records

3.12 In my opinion the medical and nursing records are inadequate following Mr Cunningham's admission to Dryad ward. The initial assessment by Dr Lord on 21st September is in my opinion competent and appropriate. The medical notes following this are inadequate and do not explain why he was commenced on subcutaneous infusions of diamorphine and midazolam. The nursing notes are variable and at times inadequate.

Appropriateness and justification of the decisions that were made

3.13 An inappropriately high dose of diamorphine and midazolam was first prescribed. There was a failure to recognise or respond to drug induced problems. Inappropriate dose escalation of diamorphine and midazolam and poor assessment by Dr Lord. The assessment by Dr Lord on 21st September 1998 was thorough and competent and a clear plan of management was outlined. There is a clear note by Dr Lord that oramorph was to be given intermittently (PRN) for pain and not regularly. It is not clear from the medical and nursing notes why Mr Cunningham was not administered the regular cocodamol he was prescribed following the initial dose he received at 1800h following admission. It is good practice to provide regular oral analgesia, with paracetamol and a mild opiate, particularly when a patient has been already taking this medication and to use prn morphine for breakthrough pain. I consider the prescription by Dr Barton on admission of prn subcutaneous diamorphine 20-200mg/24hr prn, hyoscine 200-800microg/24hr and midazolam 20-80mg/24hr to be unjustified, poor practice and potentially very hazardous. It is particularly notable that only hours earlier Dr Lord had written that oramorph was to be given intermittently and this had been underlined in the medical notes. There is no clear justification in the notes for the commencement of subcutaneous diamorphine and midazolam on the evening following admission. If increased opiate analgesia was required increasing the oramorph dose and frequency could have provided this. I would judge it poor management to initially commence both diamorphine and midazolam. The combination could result in profound respiratory depression and it would have been more appropriate to review the response to diamorphine alone before commencing midazolam.

3.14 I am concerned by the initial note entry by Dr Barton on 21st September 1998 that she was happy for nursing staff to confirm death. There was no indication by Dr Lord that Mr Barton was expected to die, and Dr Barton does not list the reason she would have cause to consider Mr Cunningham would die within the next 24 hours before he was reviewed the following day by medical staff. In my opinion it is of concern that the nursing notes suggest the diamorphine and midazolam infusions were commenced because of Mr Cunningham's behaviour recorded in the nursing entry on 22nd September.

3.15 Hyoscine was commenced on 23rd September after Mr Cunningham had become 'chesty' overnight. I consider it very poor practice that there is no record of Mr Cunningham being examined by a doctor following admission on 21st September, and a decision to treat this symptomatically with hyoscine appears to have been made by the medical staff. At this stage Mr Cunningham's respiratory signs are likely to have been due to bronchopneumonia or respiratory depression resulting in depressed clearance of bronchial secretions. A medical assessment was very necessary at this

stage to diagnose the cause of symptoms and to consider treatment with antibiotics or reduction in the dose of diamorphine and midazolam.

3.16 Again I consider it very poor practice that the midazolam was increased from 20mg/24hr to 60mg/24 hr at 2000h on 23rd September. There is no entry in the medical notes to explain this dose increase. The decision to triple the midazolam dose appears to have been made by a member of nursing staff as the nursing notes record *"agitated at 2300h, syringe driver boosted with effect."*

3.17 A medical assessment should have been obtained before the decision to increase the midazolam dose was made. At the very least Mr Cunningham's problems should have been discussed with on call medical staff. Mr Cunningham's agitation may have been due to pain, where increasing analgesia would have been appropriate, or hypoxia (lack of oxygen). If Mr Cunningham's agitation was due to hypoxia a number of interventions may have been indicated. Reducing the diamorphine and midazolam dose would have been appropriate if hypoxia was due to respiratory depression. Commencement of oxygen therapy and possibly antibiotics would have been appropriate if hypoxia was due to pneumonia. Reducing the dose diamorphine or midazolam would have been indicated if hypoxia was due to drug-induced respiratory depression. The decision to increase the midazolam dose was not appropriately made by the ward nursing staff without discussion with medical staff.

3.18 When Mr Cunningham was reviewed by Dr Lord on 24th September he was very unwell but there is not a clear description of his respiratory status or whether he had signs of pneumonia. At this stage Dr Lord notes Mr Cunningham is in pain, but does not state the site of his pain. It is not clear to me whether the subsequent alteration in infusion rate of diamorphine, hyoscine and midazolam was discussed with and sanctioned by Dr Lord or Dr Barton. I consider the increase in midazolam from 60mg/24 hr to 80mg/24 hr was inappropriate as a response to the observation that Mr Cunningham was in pain. It would have been more appropriate to increase the diamorphine dose or even consider treatment with a non-steroidal anti-inflammatory drug. The increase in midazolam dose to 80mg/24 hr would simply make Mr Cunningham less conscious than he already appears to have been (there is not a clear description of his conscious level at this stage).

3.19 The increase in hyoscine dose to 800microg/24 hr is also difficult to justify when there is no record that the management of bronchial secretions was a problem. The subsequent threefold increase in diamorphine dose later that day to 60mg/24 hr is in my view very poor practice. Such an increase was highly likely to result in respiratory depression and marked depression of conscious level, both of which could lead to premature death. The description of Mr Cunningham, was that analgesia was 'just' controlling pain and a more cautious increase in diamorphine dose, certainly no more than two fold, was indicated with careful review of respiratory status and conscious level after steady state levels of diamorphine would have been obtained about 20 hours later. A more appropriate response to deal with any acute breakthrough pain is to administer a single prn (intermittent) dose of opiate by the oral or intramuscular route, depending on whether Mr Cunningham was unable to swallow at this time.

3.20 The increase in both diamorphine dose and midazolam dose on 26th September is difficult to justify when there is no record in the medical or nursing notes that Mr Cunningham's pain was uncontrolled. Although it is possible to accept the increase in diamorphine dose may have been appropriate if Mr Cunningham was observed to be in pain, I find the further increase in midazolam dose to 100mg/24hr of great concern. I would anticipate that this dose of midazolam administered with 80mg/24hr of diamorphine would be virtually certain to produce respiratory depression and severe depression of conscious level. This would be expected to result in death in a frail individual such as Mr Cunningham. I would expect to see very clear reasons for the use of such doses recorded in the medical notes.

3.21 I can find no record of Mr Cunningham receiving food or fluids following his admission on 21st September despite a note from Dr Lord that Mr Cunningham was to receive a 'high protein diet'. There is no indication in the medical or nursing notes as to whether this had been discussed, but given that Mr Cunningham was admitted with the intention of returning to his Nursing Home (it was to be held open for 3 weeks) I would expect the notes to record a clear discussion and decision making process involving senior medical staff accounting for the decision to not administer subcutaneous fluids and/or nasogastric nutrition once Mr Cunningham was commenced on drugs which may have made him unable to swallow fluids or food.

Recorded causes of death

3.22 The recorded cause of death was bronchopneumonia with contributory causes of Parkinson's disease and sacral ulcer. A post mortem was not obtained and the recorded causes were in my opinion reasonable. It is possible that Mr Cunningham died from drug induced respiratory depression without bronchopneumonia present or from the combined effects of bronchopneumonia and drug-induced respiratory depression. Mr Cunningham was at high risk of developing pneumonia even if he had not received sedative or opiate drugs, bronchopneumonia can occur as a secondary complication of opiate and sedative induced respiratory depression. In the absence of post-mortem, radiological data (chest Xray) or recordings of Mr Cunningham's respiratory rate I would consider the recorded cause of death of bronchopneumonia as reasonable. Even if the staff had considered Mr Cunningham had drug-induced respiratory depression as a contributory factor, it would not be usual medical practice to enter this as a contributory cause of death where the administration of such drugs was considered appropriate for symptom relief.

Duty of care issues

3.23 Medical and nursing staff on Dryad ward had a duty of care to deliver medical and nursing care to attempt to heal Mr Cunningham's sacral ulcer and to document the effects of drugs prescribed. In my opinion this duty of are was not adequately met and the denial of fluid and diet and prescription of high doses of diamorphine and midazolam was poor practice and may have contributed to Mr Cunningham's death.

Summary

3.24 In summary although Mr Cunningham was admitted for medical and nursing care to attempt to heal and control pain from his sacral ulcer, Dr Barton and the ward staff appear to have considered Mr Cunningham was dying and had been admitted for terminal care. The medical and nursing records are inadequate in documenting his clinical state at this time. The initial prescription of subcutaneous diamorphine, midazolam and hyoscine by Dr Barton was in my view reckless. The dose increases undertaken by nursing staff were inappropriate if not undertaken after medical assessment and review of Mr Cunningham. I consider it highly likely that Mr Cunningham experienced respiratory depression and profound depression of conscious level due to the infusion of diamorphine and midazolam. I consider the doses of these drugs prescribed and administered were inappropriate and that these drugs most likely contributed to his death through pneumonia and/or respiratory depression.

Code A

Course of Events

4.1 Alice Wilkie was 81 years old when admitted under the care of Dr Lord, by her general practitioner on 31st July 1998 from Addenbrooke Rest Home to Phillip Ward, Department of Medicine for Elderly People, at the Queen Alexandra Hospital, Portsmouth. The general practitioner referral letter states "*This demented lady has been in this psychogeriatric care home for a year. She had a UTI early this week and has not responded to trimethoprim. Having fallen last night, she is not refusing fluids and is becoming a little dry*". The medical admitting notes record she was taking prozac (fluoxetine) syrup 20 mg once daily, codanthramer 5-10ml nocte, lactulose 10ml once daily zopiclone 1.875 or 3.75mg nocte and promazine syrup 25mg as required. On examination she had a fever and bilateral conjunctivitis but no other significant findings. The admitting doctor diagnosed a urinary tract infection and commenced intravenous antibiotics to be administered after a blood culture and catheter specimen of urine had been obtained. The following day DNR (do not resuscitate) is recorded in the notes. On 3rd August 1998 the medical notes record the fever had settled, that she was taking some fluids orally, was taking the antibiotic Augmentin elixir orally and receiving subcutaneous fluids. The notes then record (date not clear) that her Mental Test Score was 0/10 and Barthel 1/20 (indicating severe dependency). Mrs Wilkie was to be transferred to Daedalus NHS continuing care ward on 6th August 1998 with a note that her bed was to be kept at Addenbrooke Rest Home.

4.2 Following transfer on 6th August an entry in the medical notes states "*Transferred from Phillips Ward. For 4-6/52 only. On Augmentin for UTI*". Dr Lord writes on 10th August 1998 '*Barthel 2/20. Eating and drinking better. Confused and slow. Give up place at Addenbrooke's. R/V* (review) *in 1/12* (one month) *–if no specialist medical or nursing problems D* (discharge) *to a N/Home. Stop fluoxetine*'. The next entry is by Dr Barton on 21st August "*Marked deterioration over last few days. sc analgesia commenced yesterday. Family aware and happy*". The final entry is on the same day at 1830h where death is confirmed. The most recent record of the patient's weight I can find is 56Kg in April 1994.

4.3 The nursing notes, which have daily entries during her one week stay on Phillip ward note she was catheterised, was confused at times and was sleeping well prior to transfer. The nursing notes on Daedalus ward record "6/8/98 *Transferred from Philip ward QAH for 4-6 weeks assessment and observation and then decide on placement. Medical history of advanced dementia, urinary tract infection and dehydration"* and that she was seen by Dr Peters. The nursing assessment sheet notes *"does have pain at times unable to ascertain where"*. The nutrition care plan states on 6th August 1998 "*Due to dementia patient has a poor dietary intake*". And dietary intake is recorded between 12th August and 18th August but not before or following these dates. Nursing entries in the contact record state on 17th August 1998 "*Condition has generally deteriorated over the weekend Daughter seen- aware that mums condition is worsening, agrees active treatment not appropriate and to use of syringe driver if Mrs Wilkie is in pain*". There is no entry in the notes on 20th August or preceding few days indicating Mrs Wilkie was in pain.

4.4 A nursing entry on 21st August 1998 at 1255h states "*Condition deteriorating during morning. Daughter and granddaughters visited and stayed. Patient comfortable and pain free*". There are a number of routine entries in the period 6th August 1998 to death on 21st August 1998 in nutrition, pressure area care, constipation, catheter care, and personal hygiene. The nursing care plan records no significant deterioration until 21st August where it is noted death was pronounced at 2120h by staff nurse Code A Cause of death was recorded as bronchopneumonia.

4.5 The drug charts records that Dr Barton prescribed as a regular daily review (not intermittent as required) prescription diamorphine 20-200mg/24hr, hyoscine 200-800microg/24hr and midazolam 20-80mg/24hr all to be administered subcutaneously. The prescription is not dated. Drugs were first administered on 20th August, diamorphine at 30mg/24hr and midazolam 20mg/24hr from 1350h and then again on 21st August. Mrs Wilkie had not been prescribed or administered any analgesic drugs during her admission to Daedalus ward prior to administration of the diamorphine and midazolam infusions. During the period 16th-18th August she was prescribed and received zopiclone (a sedative hypnotic) 3.75mg nocte and co-danthramer 5-10ml (a laxative) orally.

Opinion on patient management

Leadership, roles, responsibilities and communication in respect of the clinicians involved

4.6 Primary responsibility for the medical care of Mrs Wilkie during her admission to Daedalus ward lay with Dr Lord, as the consultant responsible for her care. She saw Mrs Wilkie on 10th August 1998, 11 days prior to her death. My understanding is that day-to-day medical care was the responsibility of the clinical assistant Dr Barton and during out of hours period the on call doctor based at the Queen Alexander Hospital. Ward nursing staff were responsible for assessing and monitoring Mrs Wilkie and informing medical staff of any significant deterioration.

Accuracy of diagnosis and prognosis including risk assessments

4.7 The initial diagnosis of a urinary tract infection and dehydration was reasonable and appears correct. Mrs Wilkie had a diagnosis of dementia, which there was clear evidence for. The entry by Dr Lord on 10th August 1998 provides a reasonable assessment of her functional level at this time, and a plan to review appropriate placement in one month's time. No diagnosis was made to explain the deterioration Mrs Wilkie is reported to have experienced around 15th August. There is no medical assessment in the notes following 10th August except documentation on 21st August 1998 of a marked deterioration. There is no clear evidence that Mrs Wilkie was in pain although she was commenced on opiate analgesics.

Evaluation of drugs prescribed and the administration regimens

4.8 No information is recorded in the medical or nursing notes to explain why Mrs Wilkie was commenced on diamorphine and hyoscine infusions. In my opinion there was no indication for the use of diamorphine and hyoscine in Mrs Wilkie. Other oral analgesics, such as paracetamol and mild opiate drugs could and should first have been tried, if Mrs Wilkie was in pain, although there is no evidence that she was. If these were inadequate oral morphine would have

been the next appropriate choice. From the information I have seen in the notes it appears the diamorphine and midazolam may have been commenced for non-specific reasons, perhaps as a non-defined palliative reasons as it was judged she was likely to die in the near future.

4.9 I consider the undated prescription by Dr Barton of subcutaneous diamorphine 20-200mg/24hr prn, hyoscine 200-800microg/24hr and midazolam 20-80mg/24hr to be poor practice and potentially very hazardous. I consider it poor and hazardous management to initially commence both diamorphine and midazolam in a frail elderly underweight patient with dementia such as Mrs Wilkie. The combination could result in profound respiratory depression and it would have been more appropriate to review the response to diamorphine alone before commencing midazolam, had it been appropriate to commence subcutaneous analgesia, which as I have stated before was not the case.

Quality and sufficiency of the medical records

4.10 The medical and nursing records during her stay on Daedalus ward are inadequate not sufficiently detailed, and do not provide a clear picture of Mrs Wilkie's condition. In my opinion the standard of the notes falls below the expected level of documentation on a continuing care or rehabilitation ward. The assessment by Dr Lord on 10th August 1998 is the only satisfactory medical note entry during her 15 day stay on Daedalus ward.

Appropriateness and justification of the decisions that were made

4.11 As discussed above I do not consider the decision to commence diamorphine and hyoscine was appropriate on the basis of the information recorded in the clinical notes.

Recorded causes of death

4.12 There was no specific evidence that bronchopneumonia was present, although this is a common pre-terminal event in frail older people, and is often entered as the final cause of death in frail older patients. I am surprised the death certificate did not apparently refer to Mrs Wilkie's dementia as a contributory cause. It is possible Mrs Wilkie's death was due at least in part to respiratory depression from the diamorphine she received, or that the diamorphine led to the development of bronchopneumonia. However since there are no clear observations of Mrs Wilkie's respiratory observations it is difficult to know whether respiratory depression was present Mrs Wilkie deteriorated prior to administration of diamorphine and midazolam infusion, and in view of this, my opinion would be that although the opiate and sedative drugs administered may have hastened death, and these drugs were not indicated, Mrs Wilkie may well have died at the time she did even if she had not received the diamorphine and midazolam infusions.

Duty of care issues

4.13 Medical and nursing staff on Daedalus ward had a duty of care to deliver medical and nursing care, to monitor, and to document the effects of drugs prescribed to Mrs Wilkie. In my opinion this duty of care was not adequately met, the prescription of diamorphine and midazolam was poor practice and this may have contributed to Mrs Wilkie's death.

Summary

4.14 In my opinion the prescription of subcutaneous diamorphine and midazolam was inappropriate, and probably resulted in depressed conscious level and respiratory depression, which may have hastened her death. However Mrs Wilkie was a frail very dependent lady with dementia who was at high risk of developing pneumonia. It is possible she would have died from pneumonia even if she had not been administered the subcutaneous sedative and opiate drugs.

Robert WILSON

5.1 Mr Wilson was 75 years old man when he was admitted to Queen Alexandra Hospital on 22nd September 1998 after he sustained a proximal fracture of the left humerus. He was treated with morphine, initially administered intravenously and then subcutaneously. He developed vomiting. On 24th September he was given 5mg diamorphine and lost sensation in the left hand. On 29th September an entry in the medical notes states *"ref to social worker, review resus status. Not for resuscitation in view of quality of life and poor prognosis".*

5.2 On 7th October the notes record he was *"not keen on residential home and wished to return to his own home".* Code A Consultant in Old Age Psychiatry on 8th October 1998, saw him. Code A it's letter on 8th October notes that Mr Wilson had been sleepy and withdrawn and low in mood but was now eating and drinking well and appeared brighter in mood. His Barthel score was 5/20. Code A noted he had a heavy alcohol intake during the last 5 years. At the time he was seen by Code A her was prescribed thiamine 100 mg daily, multivitamins two tablets daily, senna two tablets daily, magnesium hydroxide 10 mls twice daily and paracetamol 1g four time daily. On examination he had mildly impaired cognitive function (Mini Mental State Examination 24/30). Code A it considered Mr Wilson might have developed an early dementia, which could have been alcohol related, Alzheimer's disease or vascular dementia. An antidepressant trazadone 50mg nocte was commenced. Code A states at the end of her letter "*On the practical side he may well require nursing home care though at the moment he is strongly opposed to that idea I shall be happy to arrange follow up by our team once we know when and where he is going to be discharged*". On 13th October the medical notes record a ward round took place, that he required both nursing and medical care, was at risk of falling and that a short spell in long-term NHS care would be appropriate. Reviewing the drug charts Mr Wilson was taking regular soluble paracetamol (1g four times daily) and codeine phosphate 30mg as required for pain. Between 8th and 13th October Mr Wilson was administered four doses of 30mg codeine. Mr Wilson's weight in March 1997 was 93Kg

5.3 On the 14th October Mr Wilson was transferred to Dryad Ward. An entry in the medical notes by Dr Barton reads "*Transfer to Dryad ward continuing care. HPC fracture humerus. needs help with ADL (*activities of Daily Living*), hoisting, continent, Barthel 7. Lives with wife. Plan further mobilisation".* On 16th November the notes record; '*Decline overnight with S.O.B. o/e ? weak pulse. Unresponsive to spoken work. Oedema ++ in arms and legs. Diagnosis ?silent MI, ? decreased __ function. ↑frusemide to 2 x 40mg om '.* On 17th October the notes record '*comfortable but rapid deterioration'.* On 18th October staff nurse Collins records death at 2340h. Cause of death is recorded as congestive cardiac failure.

5.4 Nursing notes state in the summary section on 14th October "*History of left humerus fracture, arm in collar and cuff. Long history of heavy drinking. LVF chronic oedematous legs. S/B Dr Barton. Oramorph 10mg/5ml given. Continent of urine – uses bottles*". On 15th October "*Commenced oramorph 10mg/5ml 4 hrly for pain in L arm. Wife seen by sis. Hamblin who explained Robert's condition is poor*". An earlier note states *"settled and slept well*". On 16th October "*seen by Dr Knapman an as deteriorated over night. Increase*

*frusemide to 80mgdaily. For A.N.C (*active nursing care*)*". Later that day a further entry states "*Patient very bubbly chest this pm. Syringe driver commenced 20mg diamorphine, 400mcgs hyoscine. Explained to family reason for driver*". A separate note on 16th October in the nursing care plan states "*More secretions – pharyngeal – during the night, but Robert hasn't been distressed. Appears comfortable*". On 17th October 0515h "*Hyoscine increased to 600mcgs as oro-pharyngeal secretions increasing. Diamorphine 20mg.*" Later that day a further entry states "*Slow deterioration in already poor condition. Requiring suction very regularly – copious amounts suctioned. Syringe driver reviewed at 15.50 s/c diamorphine 40mg, midazolam 20mcgs, hyoscine 800 mcgs*". A later note states "*night: noisy secretions but not distressing Robert. Suction given as required during night. Appears comfortable*". On 18th October "*further deterioration in already poor condition. Syringe driver reviewed at 14:40 s/c diamorphine 60mg, midazolam 40mg, hyoscine 1200mcg. Continues to require regular suction*".

5.5 The medication charts record administration of the following drugs:

14 Sep 1445h oramorph 10mg
2345h oramorph 10mg
16 Sep 1610h diamorphine 20mg/24 hr, hyoscine 400 microg/24hr subcutaneous infusion
17 Sep 0515h diamorphine 20mg/24hr, hyoscine 600 microg/24hr
1550h diamorphine 40mg/24hr, hyoscine 800 microg/24hr
midazolam 20mg/24hr
18 Sep 1450h diamorphine 60mg/24hr, hyoscine 1200 microg/24hr
midazolam 40mg/24hr

Frusemide was administered at a dose of 80mg daily at 0900h on 15th and 16th October. An additional 80 mg oral dose was administered at an unstated time on 16th October.

Opinion on patient management

Leadership, roles, responsibilities and communication in respect of the clinicians involved

5.6 Responsibility for the care of Mr Wilson during his admission to Dryad ward lay with Dr Lord as the consultant responsible for his care. My understanding is that day to day medical care was delegated to the clinical assistant Dr Barton and during the out of hours responsibility was with the on call doctor based at Queen Alexandra Hospital. Ward nursing staff were responsible for assessing and monitoring Mr Wilson and informing medical staff of any significant deterioration.

5.7 Code A was responsible for assessing Mr Wilson and making further recommendations concerning his future care when he was seen at Queen Alexandra Hospital.

Accuracy of diagnosis and prognosis including risk assessments

5.8 Dr Barton assessed Mr Wilson on 14th October the day he was transferred to Dyad ward. There was a plan to attempt to improve his mobilisation through rehabilitation. There is no record of any significant symptomatic medical problems, in particular any record that Mr Wilson was in pain in the medical

notes. The nursing notes suggest Mr Wilson was prescribed oramorph for pain in his arm following his admission to Dryad Ward. He was prescribed paracetamol to take as required but did not receive any paracetamol whilst on Dryad Ward.

5.9 Mr Wilson deteriorated on 15th September when he became short of breath. The working diagnosis was of heart failure due to a myocardial infarct. I do not consider the assessment by the on call doctor of Mr Wilson was adequate or competent. There is no record of his blood pressure, clinical examination findings in the chest (which might have indicated whether he had signs of pulmonary oedema or pneumonia). In my opinion an ECG should have been obtained that night, and a Chest Xray obtained the following morning to provide supporting evidence for the diagnosis. Mr Wilson was admitted for rehabilitation not terminal care and it was necessary and appropriate to perform reasonable clinical assessments and investigations to make a correct diagnosis.

5.10 Following treatment Mr Wilson was noted to have had a rapid deterioration. The medical and nursing teams appear to have failed to consider that Mr Wilson's deterioration may have been due to the diamorphine infusion. In my opinion when Mr Wilson was unconscious the diamorphine infusion should have been reduced or discontinued. The nursing and medical staff failed to record Mr Wilson's respiratory rate, which was likely to have been reduced, because of respiratory depressant effects of the diamorphine. The diamorphine and hyoscine infusion should have been discontinued to determine whether this was contributing to his deteriorating state. There is no record of the reason for the prescribing of the midazolam infusion commenced the day before his death. At this time the nursing notes record he was comfortable. Mr Wilson did not improve. The medical and nursing teams did not appear to consider that the diamorphine, hyoscine and midazolam infusion could be a major contributory factor in Mr Wilson's subsequent decline. The infusion should have been discontinued and the need for this treatment, in my opinion unnecessary at the time of commencement, reviewed.

Evaluation of drugs prescribed and the administration regimens

5.11 The initial prescription and administration of oramorph to Mr Wilson following his transfer to Dryad ward was in my opinion inappropriate. His pain had been controlled with regular paracetamol and as required codeine phosphate (a mild opiate) prior to his transfer, and in the first instance these should have been discontinued.

5.12 I am unable to establish when Dr Barton wrote the prescription for subcutaneous diamorphine 20-200mg/24hr, hyoscine 200-800microg/24hr, and midazolam 20-80mg/24hr as these are undated. The administration of diamorphine and hyoscine by subcutaneous infusion as a treatment for the diagnosis of a silent myocardial infarction was in my opinion inappropriate. The prescription of a single dose of intravenous opiate is standard treatment for a patient with chest pain following myocardial infarction is appropriate standard practice but was not indicated in Mr Wilson's case as he did not have pain. The prescription of an initial single dose of diamorphine is appropriate as a treatment for pulmonary oedema if a patient fails to respond to intravenous diuretics such as frusemide. Mr Wilson was not administered intravenous

frusemide or another loop diuretic. Instead only a single additional oral dose of frusemide was administered. In my opinion this was an inadequate response to Mr Wilson's deterioration. The prescription of continuous subcutaneous infusion of diamorphine and hyoscine is not appropriate treatment for a patient who is pain free with a diagnosis of a myocardial infarction and heart failure. When opiates are used to treat heart failure, close monitoring of blood pressure and respiratory rate, preferably with monitoring of oxygen saturation is required. This was not undertaken.

5.13 The increase in diamorphine dose to 40mg/24hr and then 60mg/24 hr in the following 48 hours is not appropriate when the nursing and medical notes record no evidence that Mr Wilson was in pain or distressed at this time. This was poor practice and potentially very hazardous. Similarly the addition of midazolam and subsequent increase in dose to 40mg/24hr was in my opinion highly inappropriate and would be expected to carry a high risk of producing profound depression of conscious level and respiratory drive.

Quality and sufficiency of the medical records

5.14 The initial entry in the medical records by Dr Barton on 14th October is reasonable and sufficient. The subsequent entries relating to Mr Wilson's deterioration are in my opinion inadequate, and greater detail and the results of examination findings should have been recorded. No justification for the increases in diamorphine, midazolam and hyoscine dose are written in the medical notes. The nursing notes are generally of adequate quality but I can find no record of fluid and food intake by Mr Wilson.

Appropriateness and justification of the decisions that were made

5.15 I consider the prescription of oramorph was inappropriate. The subsequent prescription and administration of diamorphine, hyoscine and midazolam was highly inappropriate, not justified by information presented in the notes and could be expected to result in profound depression of conscious level and respiratory depression in a frail elderly man such as Mr Wilson.

Recorded causes of death

5.16 The recorded cause of death was congestive cardiac failure. The limited clinical information recorded in the absence of a chest Xray result or post-mortem findings, suggest this may have been the cause of Mr Wilson's death. However in my opinion it is highly likely that the diamorphine, hyoscine and midazolam infusion led to respiratory depression and/or bronchopneumonia and it is possible that Mr Wilson died from drug induced respiratory depression.

Duty of care issues

5.17 Medical and nursing staff on Dryad ward had a duty of care to deliver appropriate medical and nursing care to Mr Wilson, and to monitor the effects of drugs prescribed. In my opinion this duty of care was not adequate. The administration of high doses of diamorphine and midazolam was poor practice and may have contributed to Mr Wilson's death.

Summary

5.18 Code A was a frail elderly man with early dementia who was physically dependent. Following his admission to Dryad ward he was, in my opinion, inappropriately treated with high doses of opiate and sedative drugs. These drugs are likely to have produced respiratory depression and/or the development of bronchopneumonia and may have contributed to his death.

Eva PAGE

6.1 Eva Page was 87 years old when admitted as an emergency on 6th February 1998 to the Department of Medicine for Elderly People at Queen Alexandra Hospital. The medical notes record that she had experienced a general deterioration over the last 5 days was complaining of nausea and reduced appetite and was dehydrated. She had felt 'depressed' during the last few weeks. On admission she was taking ramipril 5mg once daily (a treatment for heart failure and hypertension), frusemide 40mg once daily (treatment for fluid retention), digoxin 125microg once daily (to control irregular heart rate), sotalol 40 mg twice daily (to control irregular heart rate), aspirin 75 mg once daily (to prevent stroke and myocardial infarction) and sertraline 50mg once daily (an antidepressant commenced by her general practitioner on 26th January 1998). A discharge summary and medical notes relating to an admission in May 1997 states that she was admitted with acute confusion, had reduced movement on the right side and was discharged back to her residential home on aspirin. No admitting diagnosis is recorded in the clerking notes written by Dr Harris on 6th February 1998 but they record that *"patient refuses iv fluids and is willing to accept increased oral fluids"*.

6.2 On 7th February 1998 the medical notes record an opacity seen on the chest Xray and sate "*mood low. Feels frightened – doesn't know why. Nausea and ??. Little else. Nil clinically."* An increased white cell count is noted (13.0) and antibiotics commenced. A subsequent chest Xray report (undated) states there is a 5cm mass superimposed on the left hilum highly suspicious of malignancy. The medical notes on 11 February 1998 record this at the Xray meeting. On 12th February 1998 the notes record (? Code A) '*In view of advanced age aim in the management should be palliative care. Charles Ward is suitable. Not for CPR'.* On 13th February the notes record '*remains v low Appears to have 'given up' d/w son re probably diagnosis d/w RH (residential home) re ability to cope'.* The notes record *'son agrees not suitable for invasive Tx* (treatment*). Matron from RH visiting today will check on ability to cope.'*

6.3 On 19th February the notes record she fell on the ward and experienced minor cuts. On 16th February '*gradual deterioration, no pain, confused. For Charles Ward she could be discharged to community from Charles Ward'.* On 19th February the notes summarise her problems '*probable Carcinoma of the bronchus, previous left ventricular failure, atrial fibrillation, digoxin toxicity and a transient ischaemic attack, that she was sleepy but responsive, states that she is frightened but doesn't know why. Says she has forgotten things, not possible to elicit what she can't remember, low MTS (mental test score). Plan encourage oral fluids, s/c fluid over night if tolerated. Continue antidepressants*'. On 18th February the medical notes state "*No change. Awaiting Charles Ward bed*".

6.4 The nursing notes record she was confused but mobilised independently. On 19th February she was transferred to Charles Ward instead of the preferred option of a bed at Gosport Hospital, which the notes record was full ('no beds'). The Queen Alexandra Hospital medical notes record a summary of her problems on 19th February prior to transfer as follows " *Diagnosis CA bronchus probable [no histology] Diag based on CXR. PMH 95 LVF + AF 95 Digoxin toxicity 97 TIA. Admitted 6.2.98 general deterioration CXR ? Ca Bronchus.*

Well defined O lesion. Exam: sleepy but responsive answers appropriately. States that she is frightened but doesn't know why. Says she has forgotten things. Not possible to elicit what she can't remember. Low MTS" and *"Feels in general tired and very thirsty. Plan encourage oral fluids, s/c fluid overnight is tolerated continue antidepressants".*

6.5 The medical notes on 23rd February record diagnoses of depression, dementia, ? Ca bronchus, ischaemic heart disease and congestive heart failure. On 25th February Dr Lord records in the medical notes "*confused and some agitation towards afternoon – evening try tds* (three times daily) *thioridazine, son in Gosport, transfer to Gosport 27/2, heminevrin prn nocte'.* A further entry states *'All other drugs stopped by Dr Lord'.*

6.6 Mrs Page was transferred to Dryad ward at Gosport War Memorial Hospital on 27th February 1998. Dr Barton writes in the medical notes "*Transfer to Dryad ward continuing care, Diagnosis of Ca Bronchus on CXR on admission. Generally unwell off legs, not eating, bronchoscopy not done, catheterised, needs help with eating and drinking, needs hoisting, Barthel 0. Family seen and well aware of prognosis. Opiates commenced. I'm happy for nursing staff to confirm death".* The nursing notes state she was admitted for *'palliative care'*, that she had a urinary catheter (inserted on 22nd February 1998) was incontinent of faeces, and was dependent for washing and dressing but could hold a beaker and pick up small amounts of food. Barthel Index was 2/20. The nursing action plan states *'encourage adequate fluid intake'.* On 28th February an entry in the medical notes by Dr Laing (duty GP) record *'asked to see: confused. Feels 'lost' agitated esp. night/evening, not in pain, to give thioridazine 25mg tds regular, heminevrin noct.* The nursing notes record she was very distressed and that she was administered thioridazine and Oramorph 2.5ml.

6.7 On 2nd March Dr Barton records *'no improvement on major tranquillisers. I suggest adequate opioids to control fear and pain; Son to be seen by Dr Lord today'.* A subsequent entry by Dr Lord on the same day states *' spitting out thioridazine, quieter on prn sc diamorphine. Fentanyl patch started today. Agitated and calling out even when staff present (diagnoses) 1) Ca Bronchus 2) ? Cerebral metastases. -ct* (continue) *fentanyl patches.'* A further entry by Code A Lord that day records *'son seen. Concerned about deterioration today. Explained about agitation and that drowsiness was probably due in part to diamorphine. He accepts that his mother is dying and agrees we continue present plan of Mx* (management)".

6.8 On 2nd March the nursing notes record "*commenced on Fentanyl 25mcg this am. Very distressed this morning seen by Dr Barton to have and diamorphine 5mg i/m (intramuscular) same given 0810h by a syringe driver.* A further entry the same day states *"S/B Dr Lord. Diamorphine 5mg i/m given for syringe driver with diamorphine loaded*". On 3rd March a rapid deterioration in Mrs Page's condition is recorded *'Neck and left side of body rigid – right side rigid,* At 1050h diamorphine and midazolam were commenced by syringe driver. Death is recorded later that day at 2130h, 4 days following admission to Dyad ward.

6.9 The prescription charts (which are incompletely copied in notes made available to me) indicate she received the following drugs during this admission Two doses of intramuscular diamorphine 5 mg were administered at 0800 and 1500h (date not visible)

28 Feb 1998	1300h thioridazine 25mg
	1620h oramorph 5mg
	2200h heminevrin 250mg in 5ml
1 Mar 1998	0700h thioridazine 25 mg
	1300h thioridazine 25 mg
	2200h heminevrin 250mg
2 Mar 1998	0700h thioridazine 25mg
	0800h fentanyl 25microg
3 Mar 1998	1050h diamorphine 20mg/24hr, midazolam 20 mg/24hr by subcutaneous infusion

On 27th February Dr Barton prescribed thioridazine 25mg (prn tds) and Oramorph (10mg/5ml) 4hrly prn. On 2nd March Dr Barton prescribed fentanyl 25microg patch (x3 days) to take as required (prn). On 3rd March Dr Barton prescribed diamorphine 20-200mg/24hr, hyoscine 200-800ucg/24hr and midazolam 20-80mg/24hr by subcutaneous infusion.
The notes do not indicate that the fentanyl patch was removed and I would assume this was continued when the diamorphine and midazolam infusion was commenced.

Opinion on patient management

Leadership, roles, responsibilities and communication in respect of the clinicians involved

6.10 Primary responsibility for the medical care of Mrs Page during her admission to Dryad Ward lay with Dr Lord, as the consultant responsible for his care. She saw Mrs Page 2 days before her transfer to Dryad ward and two days following her admission, the day before she died. My understanding is that day-to-day medical care was the responsibility of the clinical assistant Dr Barton and during out of hours period the on call doctor based at the Queen Alexander Hospital. Ward nursing staff were responsible for assessing and monitoring Mrs Page and informing medical staff of any significant deterioration.

Accuracy of diagnosis and prognosis including risk assessments

6.11 The assessment and management of Mrs Page at Alexandra Hospital was in my opinion competent and considered. From the information in the clinical notes I would agree with the diagnosis of probable carcinoma of bronchus. The decision to prescribe an antidepressant was in my opinion appropriate. Prior to transfer to Dryad ward she was not in pain but was transferred for palliative care. Although Mrs Page was clearly very dependent and unwell, it is not clear why Dr Barton prescribed opiates to Mrs Page on admission to Dryad ward when there is no evidence she was in pain. I suspect the reason was to provide relief for Mrs Page's anxiety and agitation. This is a reasonable indication for opiates in the palliative care of a patient with known inoperable carcinoma. Mrs Page was noted to be severely dependent, Barthel Index 0, and in conjunction with a probable carcinoma of the bronchus the assessment that she required palliative care and was likely to die in the near future was appropriate.

Evaluation of drugs prescribed and the administration regimens

6.12 The prescription of the major tranquilliser thioridazine for anxiety was reasonable and appropriate. The prescribing of the sedative/hypnotic drug heminevrin was similarly reasonable although potential problems of sedation from the combination need to be considered. Mrs Page was not in pain but I consider the prescription of oramorph on 28th February to attempt to improve her distress was reasonable. By 2nd March Mrs Page remained very distressed despite prescription of Oramorph, thioridazine and heminevrin. Since the notes reported she was more settled following intramuscular diamorphine and she had been spitting out her oral medication, I would consider it appropriate to prescribe a transdermal fentanyl patch to provide continuing opioid drugs to Mrs Page. The lowest dose patch was administered but it would have been important to be aware of the potential for depression of respiration and/or conscious level that could occur.

6.13 I do not understand why subcutaneous diamorphine and midazolam infusions were commenced on 3rd March when Mrs Page had deteriorated whilst on the fentanyl patch. There is no indication in the notes that Mrs Page was in pain or distressed. The notes describe her as having undergone a rapid deterioration, which could have been due to a number of different causes, including a stroke or an adverse effect of the fentanyl patch. In my opinion the prescription by Dr Barton of subcutaneous diamorphine 20-200mg/24hr prn, hyoscine 200-800microg/24hr and midazolam 20-80mg/24hr was poor practice and potentially very hazardous. I would judge it poor management to initially commence both diamorphine and midazolam in a frail elderly underweight patient such as Mrs Page who was already receiving transdermal fentanyl. I would expect very clear reasons to support the use of the drugs to be recorded in the medical notes. The combination could result in profound respiratory depression and there are no symptoms recorded which suggest the administration of either drug was appropriate.

Quality and sufficiency of the medical records

6.14 The medical and nursing records relating to Mrs Page's admission to Dryad ward are in my view of adequate quality, although as stated above the reasons for the use of midazolam and diamorphine are not recorded in either the medical or nursing notes.

Appropriateness and justification of the decisions that were made

6.15 In my opinion the majority of management and prescribing decisions made by medical and nursing staff were appropriate. The exception is the prescription of diamorphine and midazolam on the day of Mrs Page's death. From the information I have seen in the notes it appears that Dr Barton may have commenced the diamorphine and midazolam infusion for non-specific reasons or for non-defined palliative reasons when it was judged she was likely to die in the near future.

Recorded causes of death

6.16 In the absence of a post-mortem the recorded cause of death is reasonable. Mrs Page had a probable carcinoma of the bronchus and experienced a slow deterioration in her general health and functional abilities. It is possible that Mrs Page died from drug induced respiratory depression. However Mrs Page was at high risk of dying from the effects of her probable carcinoma of the bronchus even if she had not received sedative and opiate drugs. Bronchopneumonia

can also occur as a complication of opiate and sedative induced respiratory depression but also in patients deteriorating from malignancy. In the absence of post-mortem, radiological data (chest Xray) or recordings of Mrs Page's respiratory rate I would consider the recorded cause of death was possible. The deterioration on between the 2nd March and 3rd March could have been secondary to the fentanyl patch she received but again could have occurred in the absence of receiving this drug. There are no accurate records of Mrs Page's respiratory rate but significant potentially fatal respiratory depression was likely to have resulted could have resulted from the combination of diamorphine, midazolam and fentanyl.

Duty of care issues

6.17 Medical and nursing staff on Dryad ward had a duty of care to deliver medical and nursing care, to monitor Mrs Page and to document the effects of drugs prescribed. In my opinion this duty of care was adequately met except during the last day of her life when the prescription of diamorphine and midazolam was poor practice and may have contributed to Mrs Wilkie's death.

Summary

6.18 Mrs Page was a frail elderly lady with probable carcinoma of the bronchus who had been deteriorating during the two weeks prior to admission to Dryad ward. In general I consider the medical and nursing care she received was appropriate and of adequate quality. However I cannot identify a reason for the prescription of subcutaneous diamorphine, midazolam and hyoscine by Dr Barton on the 3rd March. In my view this was an inappropriate, potentially hazardous prescription. I would consider it highly likely that Mrs Page experienced respiratory depression and profound depression of conscious level from the combination of these two drugs and fentanyl but I cannot exclude other causes for her deterioration and death at this time such as stroke or pneumonia.

Opinion on clinical management at Gosport War Memorial Hospital based on review of five cases presented by Hampshire Police

7.1 My opinion on the five cases I have been asked to review at Gosport War Memorial Hospital must be considered in context. My understanding is that the five cases have been selected by Hampshire Police because of concerns expressed relating to the management of these patients. Therefore my comments should not be interpreted as an opinion on the quality of care in general at Gosport War Memorial Hospital or of the general quality of care by the clinicians involved. My comments also relate to a period 2-4 years ago and the current clinical practice at the hospital may be very different today. An opinion on the quality of care in general at the hospital or of the clinicians would require a systematic review of cases, selected at random or with pre-defined patient characteristics. Examination of selected cases is not an appropriate mechanism to comment on the general quality of care of an institution or individual practitioners.

7.2 However having reviewed the five cases I would consider they raise a number of concerns that merit further examination by independent enquiry. Such enquiries could be made through further police interviews or perhaps more appropriately through mechanisms within the National Health Service, such as the Commission for Health Improvement, and professional medical and nursing bodies such as the General Medical Council or United Kingdom Central Council for Nursery, Midwifery and Health Visiting.

7.3 My principle concerns relate to the following three areas of practice: prescription and administration of subcutaneous infusions of opiate and sedative drugs in patients with non-malignant disease, lack of training and appropriate medical supervision of decisions made by nursing staff, and the level of nursing and non-consultant medical skills on the wards in relation to the management of older people with rehabilitation needs.

7.4 In all five cases subcutaneous infusions of diamorphine and in combination with sedative drugs were administered to older people who were mostly admitted for rehabilitation. One patient with carcinoma of the bronchus was admitted for palliative care. Although intravenous infusion of these drugs are used frequently in intensive care settings, very close monitoring of patients is undertaken to ensure respiratory depression does not occur. Subcutaneous infusion of these drugs is also used in palliative care, but the British National Formulary indicates this route should be used only when the patient is unable to take medicines by mouth, has malignant bowel obstruction or where the patient does not wish to take regular medication (Appendix 2). In only one case were these criteria clearly fulfilled i.e. in Mrs Page who was refusing to take oral medication. Opiate and sedative drugs used were frequently used at excessive doses and in combination with often no indication for dose escalation that took place. There was a failure by medical and nursing staff to recognise or respond to severe adverse effects of depressed respiratory function and conscious level that seemed to have occurred in all five patients. Nursing and medical staff appeared to have little knowledge of the adverse effects of these drugs in older people.

7.5 Review of the cases suggested that the decision to commence and increase the dose of diamorphine and sedative drugs might have been made by nursing staff without appropriate consultation with medical staff. There is a possibility that prescriptions of subcutaneous infusions of diamorphine, midazolam and hyoscine may have been routinely written up for many older frail patients admitted to Daedalus and Dryad wards, which nurses then had the discretion to commence. This practice if present was highly inappropriate, hazardous to patients and suggests failure of the senior hospital medical and managerial staff to monitor and supervise care on the ward. Routine use of opiate and sedative drug infusions without clear indications for their use would raise concerns that a culture of "involuntary euthanasia" existed on the ward. Closer enquiry into the ward practice, philosophy and individual staff's understanding of these practices would be necessary to establish whether this was the case. Any problems may have been due to inadequate training in management of older patients. It would be important to examine levels of staffing in relation to patient need during this period, as the failure to keep adequate nursing records could have resulted from under-staffing of the ward. Similarly there may have been inadequate senior medical staff input into the wards, and it would be important to examine this in detail, both in terms of weekly patient contact and in time available to lead practice development on the wards. My review of Dr Lord's medical notes and her statement leads me to conclude she is a competent, thoughtful geriatrician who had a considerable clinical workload during the period the above cases took place.

7.6 I consider the five cases raise serious concerns about the general management of older people admitted for rehabilitation on Daedalus and Dryad wards and that the level of skills of nursing and non-consultant medical staff, particularly Dr Barton, were not adequate at the time these patients were admitted.

7.7 Having reviewed the five cases presented to me by Hampshire Police, I consider they raise serious concerns about nursing and medical practice on Daedalus and Dryad wards at Gosport War Memorial Hospital. In my opinion a review of practice at the institution is necessary, if this has not already taken place. I would recommend that if criminal proceedings do not take place, that these cases are brought to the attention of the General Medical Council and United Kingdom Central Council for Nursery, Midwifery and Health Visiting, in relation to the professional competence of the medical and nursing staff, and the Commission for Health Improvement, in relation to the quality of service provided to older people in the Trust.

APPENDIX 1

Pharmacology of Opiate and Sedative Drugs

Morphine

8.1 Morphine is a potent opiate analgesic considered by many to the 'drug of choice' for the control of acute pain (Therapeutic Drugs Dollery). Recommended starting dosage regimens for a fit adult of 70Kg are for intravenous bolus dosing 2.5mg every 5 min until analgesia achieved with monitoring of the duration of pain and dosing interval, or a loading dose of 5-15mg over 30min than 2,5mg – 5mg every hour. A standard reference text recommends 'morphine doses should be reduced in elderly patients and titrated to provide optimal pain relief with minimal side effects'. Morphine can be used for sedation where sedation and pain relief are indicated, Dollery comments *'it should be noted that morphine is not indicated as a sedative drug for long-term use. Rather the use of morphine is indicated where the requirement for pain relief and sedation coexist such as in patients admitted to intensive care units and other high dependency areas, the morphine dose should be titrated to provide pain relief and an appropriate level of sedation. Frequently other pharmacological agents (e.g.: benzodiazepines) are added to this regimen to increase the level of sedation".*

8.2 Diamorphine

8.3

8.4 **Fentanyl**

8.5 Fentanyl is a transdermal opioid analgesic available as a transdermal patch. The '25' patch releases 25microg/hr.

8.6 The British National Formulary (copy of prescribing in palliative care attached Appendix 2) comments on the use of syringe drivers in prescribing in palliative care that drugs can usually be administered by mouth to control symptoms, and that indications for the parenteral route are: patient unable to take medicines by mouth, where there is malignant bowel obstruction, and where the patient does not wish to take regular medication by mouth, It comments that staff using syringe drivers should be adequately trained and that incorrect use of syringe drivers is a common cause of drug errors.

Heminevrin

Midazolam

8.1 Midazolam is a benzodiazepine sedative drug. It is used as a hypnotic, preoperative medication, sedation for procedures such as dentistry and GO endoscopy, long-term sedation and induction of general anaesthesia. Iot is not licensed for subcutaneous use, but is described in the British National Formulary prescribing in palliative care section as 'suitable for a very restless patient: it is given in a subcutaneous infusion dose of 20-100mg/24 hrs.

8.2 DA standard text describes the use of sedation with midazolam in the intensive care unit setting, and states, "*sedation is most commonly met by a combination of a benzodiazepine and an opioid, and midazolam has generally replaced diazepam in this respect".* It goes on to state, "in critically ill patients, prolonged sedation may follow the use of midazolam infusions as a result of delayed administration". Potentially life threatening adverse effects are described, "Midazolam can cause dose-related CNS depression, respiratory and

cardiovascular depression. There is a wide variation in susceptibility to its effects, the elderly being particularly sensitive. Respiratory depression, respiratory arrest, hypotension and even death have been reported following its use usually during conscious sedation. The elderly are listed as a high-risk group; the elderly are particularly sensitive to midazolam. The dose should be reduced and the drug given slowly intravenously in a diluted form until the desired response is achieved. In drug interactions the following is stated. "*midazolam will also potentiate the central depressant effects of opioids, barbituates, and other sedatives and anaesthetics, and profound and prolonged respiratory depression might result.*

8.3

Hyoscine

8.4 The British National Formulary describes hyoscine hydrobromide as an antagonist (blocking drug) of acetylcholine. It reduces salivary and respiratory secretions and provides a degree of amnesia, sedation and antiemesis (antinausea). IN some patients, especially the elderly, hyoscine may cause the central anticholinergic syndrome (excitement, ataxia, hallucinations, behavioural abnormalities, and drowsiness). The palliative care section describes it as being given in a subcutaneous infusion dose of 0.6-2.4mg/24 hours.

8.5

Use of syringe drivers

8.1 The BNF states 'oral medication is usually satisfactory unless there is severe nausea and vomiting, dysphagia, weakness, or coma in which case parenteral medication may be necessary. In the pain section it comments the non-opioid analgesics aspirin or paracetamol given regularly will often make the use of opioids unnecessary. An opioid such as codeine or dextropropoxyphene alone or in combination with a non-opioid analgesic at adequate dosage may be helpful in the control of moderate pain id non-opioids are not sufficient. If these preparations are not controlling the pain, morphine is the most useful opioid analgesic. Alternatives to morphine are hydromoprhine, oxycodone and transdermal fentanyl. In prescribing morphine it states 'morphine is given as an oral solution or as standard tablets every 4 hour, the initial dose depending largely on the patient's previous treatment. A dose of 5-10mg is enough to replace a weaker analgesic. If the first dose of morphine is no more effective than the previous analgesic it should be increased by 50% the aim being to choose the lowest dose which prevents pain. The dose should be adjusted with careful assessment of the pain and the use of adjuvant analgesics (such as NSAIDs) should also be considered. Although morphine in a dose of 5-10mg is usually adequate there should be no hesitation in increasing it stepwise according to response to 100mg or occasionally up to 500mg or higher if necessary. The BNF comments on the parenteral route '*diamorphine is preferred for injection. The equivalent intramuscular or subcutaneous dose of diamorphine is approximately a third of the oral dose of morphine.*'

8.2 In the chapter on pain relief in 'Drugs and the Older Person' Crome writes on the treatment of acute pain ' *treat the underlying cause and give adequate pain relief. The nature of the painful condition, the response of the patient and the presence of comorbidity will dictate whether to start with a mild analgesic or to go immediately to a more potent drug. In order to avoid the situation that patients remain in pain, "starting low" must be followed by regular re-evaluation with, if necessary, frequent increases in drug dose. The usual method of*

prescribing morphine for chronic pain is to start with standard oral morphine in a dose of 5-10mg every four hours. The dose should be halved in frail older people.

Prescribing for the Elderly

The British National Formulary states in Prescribing for the Elderly section "*The ageing nervous system shows increased susceptibility to many commonly used drugs, such as opioid analgesics, benzodiazepines, antipsychotics and antiparkinsonian drugs, all of which must be used with caution*".

APPENDIX 2

BNF Prescribing in palliative care

Medical Report:
concerning the case of Gladys Mable Richards deceased

Prepared for:

Hampshire Constabulary
Major Crime Complex, Fratton Police Station, Kingston Crescent,
North End, Portsmouth, Hampshire PO2 8BU

by: Professor Brian Livesley MD FRCP
The University of London's Professor in the Care of the Elderly
Imperial College School of Science, Technology, & Medicine
The Chelsea and Westminster Hospital, London SW10 9NH

For the purpose of ... providing an independent view about treatment given to Mrs Gladys RICHARDS and the factor(s) associated with her death.

Synopsis

1. At the age of 91 years, Mrs Gladys RICHARDS was an in-patient in Daedalus ward at Gosport War Memorial Hospital.

1.1. A registered medical practitioner prescribed the drugs diamorphine, haloperidol, midazolam, and hyoscine for Mrs Gladys RICHARDS.

1.2. These drugs were to be administrated subcutaneously by a syringe driver over an undetermined number of days.

1.3. They were given continuously until Mrs RICHARDS became unconscious and died.

1.4. During this period there is no evidence that Mrs RICHARDS was given life sustaining fluids or food.

1.5. It is my opinion that as a result of being given these drugs, Mrs RICHARDS's death occurred earlier than it would have done from natural causes.

CONTENTS

The writer's declaration

1. This report consisting of thirty-four pages is true to the best of my knowledge and belief and I make it knowing that if tendered in evidence, I shall be liable for prosecution if I have wilfully stated in it anything that I know to be false or do not believe to be true.

Introduction

2. The documents with which I have been provided and the visits I have made to the hospitals involved in this enquiry are listed in the Appendix A.

2.1. Appendix B contains facts of the environment provided by the statements of Mrs Gillian MACKENZIE (the elder daughter of Mrs Gladys RICHARDS (deceased)) and Mrs Lesley Frances LACK (the younger daughter).

2.2. I have indicated any medical terms in **bold type**. I have defined these terms in a glossary in Appendix C.

2.3. I have included in Appendix D references to published material.

2.4. Appendix E contains details of my qualifications and experience.

2.5. This report has been presented on the basis of the information available to me—should additional information become available my opinions and conclusions may be subject to review and modification.

Information relating to Mrs Gladys Richards (deceased)

3. Mrs Gladys Mable RICHARDS (née Beech) was born on Code A and died on 21st August 1998 aged 91 years.

3.1. Mrs Richards has two daughters. They are Mrs Gillian MACKENZIE (the elder daughter) and Mrs Lesley Frances LACK.

3.1.1. Mrs Lack is a retired Registered General Nurse. She retired during 1996 after 41 years continuously in the nursing profession. For 25 years prior to her retirement she was involved in the care of elderly people. For 20 years prior to retirement she held supervisory and managerial positions in this particular field of nursing.

3.2. The Glen Heathers Nursing Home is a private registered nursing and residential home at Lee on the Solent, Hampshire Code A is a general practitioner who visits.

3.3. The Royal Hospital Haslar is an acute general hospital in Gosport, Hampshire serviced by the Armed Forces at the time of the incident but available as a National Health Service facility to local people.

3.4. Gosport War Memorial Hospital is part of the Portsmouth Healthcare NHS Trust.

3.4.1. Daedalus ward is a continuing care and rehabilitation ward at Gosport War Memorial Hospital.

3.5. Dr Jane Ann BARTON is a registered medical practitioner who in 1988 took up a part-time post as clinical assistant in elderly medicine. This post became centered at Gosport War Memorial Hospital. She retired from this part-time post in the year 2000.

3.6. Mr Philip James BEED is the clinical manager and charge nurse on Daedalus ward at Gosport War Memorial Hospital. Ms Margaret COUCHMAN and Ms Christine JOICE are registered general nurses who were working on Daedalus ward at the time of the incident.

3.7. Dr Anthea Everista Geredith LORD is a consultant physician, within the department of elderly medicine of Portsmouth Healthcare NHS Trust, who was usually responsible for the patients on Daedalus ward and who was on study leave on 17/18 August 1998.

3.7.1. Other consultant physicians from the department of elderly medicine provide on-call consultant physician cover when Dr LORD is absent from duty.

Relevant aspects of Mrs RICHARDS's medical history

4. Mrs RICHARDS became resident at the Glen Heathers Nursing Home on 5th August 1994 at the age of 87 years and although disorientated and confused she was able to wash and dress herself and able to go up and down stairs and walk well.

4.1. It is noted that she also had a past medical history of bilateral deafness for which she required hearing aids.

4.1.1. Unfortunately both of her hearing aids were lost by December 1997 while she was at the Glen Heathers Nursing Home and had not been replaced by July 1998 when she was admitted to Daedalus ward at Gosport War Memorial Hospital).

4.1.2. It is noted that on 8th July 1998 her general practitioner Code A wrote to the audiologist at Queen Alexandra Hospital, Cosham requesting an '**URGENT** [sic]' domiciliary visit to Glen Heathers Nursing Home. This was '... with a view to supplying her [Mrs RICHARDS] with two new hearing aids.... Since her poor hearing probably contributes to her

confusional state I would be grateful if you would visit with a view to fitting of replacement aids as soon as possible please.'

4.2. It is also noted that Mrs RICHARDS had had operations for the removal of cataracts and required glasses.

4.2.1. Unfortunately her spectacles were also lost at the Glen Heathers Nursing Home and had not been replaced by August 1998 when she was admitted to Daedalus ward at Gosport War Memorial Hospital.

4.2.2. As Dr BASSETT had noted Mrs RICHARDS poor hearing probably contributed to her confusional state. The absence of her spectacles would also make it difficult for Mrs RICHARDS to be aware of what was going on around her, further aggravate her confusional state due to lack of sensory stimulation, and increase her dependency on others for her normal daily activities.

4.2.3. The absence of both her hearing aids and her spectacles would make the assessment of and communication with Mrs RICHARDS extremely difficult.

4.2.3.1. It is noted that such sensory deprivation can produce and aggravate confusional and disorientated states.

4.3. At the beginning of 1998, she had become increasingly forgetful and less able physically but was inclined to wander and she had about a six months' history of falls.

4.4. On 29th July 1998, at the Glen Heathers Nursing Home, Mrs RICHARDS developed a fracture of the neck of her right femur [thighbone] and she was transferred to the Royal Hospital Haslar, Gosport.

4.4.1. In the Accident & Emergency department she was given 2.5mg of **morphine** and 50 mg of **cyclizine** at 2300 hours to relieve her pain and distress. She was known to be taking **haloperidol** 1mg twice daily and **Tradazone** 100mg at night.

4.5. On 30th July 1998 Mrs RICHARDS had a right cemented hemiarthroplasty [an artificial hip joint inserted].

4.5.1. Post-operatively she was given 2.5 mg morphine intravenously on July 30th at 0230 hours, 31st at 0150 and 1905 hours, and on August 1st at 1920 hours and 2nd at 0720 hours. From August 1st –7th she was weaned over to two tablets of **co-codamol,** requiring these on average twice daily for pain relief.

4.5.2. On 3rd August 1998 it was noted 'All well. Sitting out early mobilization'.

4.6. On 5th August 1998, Dr REID, a consultant geriatrician, saw her. He stated in a letter that '... she appeared to have a little discomfort on passive movement of the right hip. I understand that she has been sitting out in a chair and I think that, despite her dementia, she should be given the opportunity to try to re-mobilise. I will arrange for her transfer to Gosport Memorial Hospital.'

4.6.1. Dr REID also noted that Mrs RICHARDS had continued on Haloperidol and '... her Trazodone has been omitted. According to her daughters it would seem that since her Tradozone has been omitted she has been much brighter mentally and has been speaking to them at times.'

4.7. A discharge letter, dated 10th August 1998, was sent by the sergeant staff nurse at the Royal Hospital Haslar and addressed to 'The Sister in Charge Ward [sic] Memorial Hospital, Bury Road, Gosport, Hants.' It contained the following information:-

4.7.1. After the operation Mrs RICHARDS became '...fully weight bearing, walking with the aid of two nurses and a **Zimmer frame**.' She was noted to require 'total care with washing and dressing, eating and drinking....' She was '... continent, when she become[s] fidgety and agitated it means she wants the toilet....' She 'Occasionally says recognisable words, but not very often.' Her wound 'Is healed, clean and and dry.'

4.8. On 11th August 1998, Mrs RICHARDS was transferred to Daedalus ward at the Gosport War Memorial Hospital. She was not in pain and had been fully weight bearing at the Royal Hospital Haslar walking with the aid of two nurses and a Zimmer frame.

4.8.1. At the Gosport War Memorial Hospital there was an unsigned 'Summary' record which is apparently a Nursing record and this states:-

4.8.1.1. '11-8-98 Addmitted [sic] from E6 Ward Royal Hospital Haslar, into a continuing care bed. Gladys had sustained a right fractured neck of Femur on 30th July 1998 in Glen Heathers Nursing Home. She has had a right cemented hemi-arthroplasty and she is now fully weight bearing, walking with the aid of two nurses and a Zimmer frame. Daughter visits regularly and feeds mother. She wishes to be informed Day or night of any deterioration in mothers condition....'

4.8.2. The contiguous 'Assessment Sheet' states, 'Patient has no apparent understanding of her circumstances due to her impaired mental condition ... Deaf in both ears ... Cataract operation to both eyes ... occasionally says recognisable words, but not very often ... soft diet. Enjoys a cup of tea ... requires feeding ... Dental/Oral status Full "Set" – keeps teeth in at night.'

4.8.3. The 'Patient Medication Information' states, '11.8.98 ... Haloperidol O[rally] 1 mcg [looks like 'mcg' but probably is 'mg' since this drug is not prescribed in single **microgram** doses] B.D. [twice daily]'

4.9. ??[initials]B [subsequently identified as Dr BARTON] has written in the medical case records '11-8-98 Transferred to Daedalus Ward Continuing Care.... O/E [on examination] Impression frail demented lady [paragraph] not obviously in pain [paragraph] Please make comfortable [paragraph] transfers with hoist Usually continent needs help with **ADL [activities of daily living]**.... I am happy for nursing staff to confirm death.'

4.10. At 1300 hours on the 13th August 1998 the Nursing Contact Record states 'Found on floor at 13.30hrs [sic]. Checked for injury none apparent at time hoisted into safer chair 20.00 [hours][altered on record to 19.30] pain Rt [right] hip internally rotated. Dr BRIGG contacted advised Xray AM [in the morning] & **analgesia** during the night. Inappropriate to transfer for Xray this PM [evening] [initialled signature (? by whom)] RGN [Registered General Nurse] [next line] Daughter informed.'

4.11. Dr BARTON has recorded '14-8-98 Sedation/pain relief has been a problem screaming not controlled by haloperidol 1 [illegible symbol or word] but very sensitive to **oramorph**. Fell out of chair last night ... Is this lady well enough for another surgical procedure?'

4.12. In her contiguous note Dr BARTON has recorded '14-8-98 Dear [?] Cdr [Commander] Code A Further to our telephone conversation thank you for taking this unfortunate lady who slipped from her chair at 1.30 pm yesterday and appears to have dislocated her R[ight] hip.... She has had 2.5ml of 10mg/5ml Oramorph at midday.'

4.12.1. According to the letter signed by Philip BEED, Mrs RICHARDS was given 10mgs of Oramorph at 1150 hours on 14th August 1998 prior to being transferred back to the Royal Hospital Haslar.

4.13. The Nursing Contact Record at Daedalus ward continues:-

4.13.1. '14/8/98 am [morning] R[ight] Hip Xrayed – Dislocated [paragraph] Daughter seen by Dr BARTON & informed of situation. For transfer to Haslar A&E [accident and emergency department] for reduction under sedation [initialled signature]'

4.13.2. 'pm [afternoon or evening of 14th August 1998] Notified that dislocation has been reduced. [Mrs RICHARDS] To stay in Haslar [hospital] for 48 hours then return to us [[initialled signature] Family aware.'

4.14. At the Royal Hospital Haslar (at 1400 hours) Xray having confirmed that the hemiarthroplasty had dislocated, intravenous sedation using 2 mgs of midazolam

allowed the dislocation to be corrected by traction. The procedure was described as 'Under sedation c [with] CVS/RS [cardiovascular and respiratory systems] monitoring. ... Easy reduction.' Mrs RICHARDS was noted to be 'rather unresponsive following the sedation. The [She] gradually became more responsive....' She was then admitted the Royal Hospital for 48 hours observation.

4.15. Apart from two tablets of co-codamol on the 15th August 1998, she did not need to be given any pain relief following the reduction of her hip dislocation.

4.15.1. Two days later, on 17th August 1998, it was recorded that 'She was fit for discharge that day and she was to remain in straight knee splint for four weeks. In the discharge letter from Haslar Hospital it was also recorded that Mrs RICHARDS was to return to Daedalus Ward. It was further stated that 'She has been given a canvas immobilising splint to discourage any further dislocation, and this must stay in situ for four weeks. When in bed it is advisable to encourage abduction by using pillows or abduction wedge. She can however mobilise fully weight bearing.'

4.16. On 17th August 1998 it was also recorded that she was 'Fit for discharge today (Gos[port] War Mem[orial hospital). To remain in straight knee splint for 4/52 [four weeks] ... No follow-up unless complications.'

4.17. She was returned to Daedalus ward in the Gosport War Memorial Hospital later that day but in a very distressed state. The Daedalus ward nursing record states 'Returned from R.N. Haslar, patient very distressed appears to be in pain. No canvas under patient – transferred on sheet by crew To remain in straight knee splint for 4/52 [four weeks] For pillow between legs at night (abduction) No follow-up unless complications.'

4.17.1. Mrs RICHARDS was given Oramorph 2.5 mg in 5mls. The nursing record for 17th August 1998 further states '1305 [hours] ... Daughter reports surgeon to say her mother must not be left in pain if dislocation occurs again. Dr Barton contacted and has ordered an Xray. M. COUCHMAN. [paragraph] pm Hip Xrayed at 1545 [hours] Films seen by Dr PETERS & radiologist & no dislocation seen. For pain control overnight & review by Dr BARTON mane [in the morning]. ?[illegible nurse signature]

4.17.1.1. This radiograph was reported by Dr. DOMJAN, Consultant Radiologist as showing 'RIGHT HIP: The right hemiarthroplasty is relocated in the **acetabulum**.'

4.18. On 17th August 1998, Dr BARTON noted 'Readmission to Daedalus from RHH [Royal Hospital Haslar] Closed reduction under iv [intravenous] sedation remained unresponsive for some hours now appears peaceful. Plan Continue haloperidol [paragraph] Only give oramorph if in severe pain See daughter again.'

4.19. On 18th August 1998, Dr BARTON recorded 'Still in great pain [paragraph] Nursing a problem. [paragraph] I suggest sc[subcutaneous] diamorphine/Haloperidol/midazolam [paragraph] I will see daughters today [paragraph] please make comfortable.'

4.20. The nursing Contact Record on Daedalus ward in the Gosport War Memorial Hospital continues:-

4.20.1. '18/8/98 am Reviewed by Dr Barton. For pain control via syringe driver. [paragraph] 1115 Treatment discussed with both daughters [Mrs LACK and Mrs MACKENZIE]. They agree to use of **syringe driver** to control pain [It is noted that Mrs LACK has disagreed with this statement] & allow nursing care to be given. [paragraph] 1145 Syringe driver diamorphine 40 mg. Haloperidol 5 mg, Medazolam [midazolam] 20 mg commenced'

4.20.2. '18/8/98 20.00 Patient remained peaceful and sleeping. Reacted to pain when being moved – this was pain in both legs. [paragraph] Daughter quite upset and angry about mother's condition, but appears happy that she is pain free at present. C JOICE.'

4.20.2.1. It is noted that a 'disturbance reaction' occurs in patients when they are moved that is easily mistaken for pain requiring specific treatment. It is noted here that Mrs RICHARDS was described as being 'pain free' at this time apart from when she was being moved.

4.20.3. The nursing Contact Record continues 'Daughter, Jill, stayed the night with Gladys [Mrs RICHARDS], grandson arrived in early hours of morning [initialled signature; dated '19/8/98'] [paragraph] He would like to discuss Grand mother's condition with someone – either Dr. Barton or Phillip Beed later today [initialled signature]' [paragraph] '19/8/98 am Mrs Richards comfortable. [paragraph] Daughters seen. Unhappy with various aspects of care, complain[t] to be handled officially by Mrs S Hutchings Nursing co-ordinator [initialled signature]'

4.20.4. It is noted that there is no continuing nursing Contact Record for the 20th August 1998.

4.20.5. The contiguous nursing Contact Record states '21/8/98 12.13 [hours] Patient's [Mrs RICHARDS] overall condition deteriorating, medication keeping her comfortable. Daughters visited during the morning. C JOICE'

4.21. Dr BARTON's next contiguous medical record was on 21st August 1998 when she wrote 'Much more peaceful [paragraph] needs Hyoscine for rattly chest'.

4.21.1. It is noted that Mrs RICHARDS was already being given hyoscine at this time and had been doing so continuously since 19th August 1998.

4.21.2. Nurse GRIFFIN made the next note in the medical records on 21st August 1998 stating that Mrs Richards was dead at 2120 hours.

4.22. The Nursing Care Plan records state:-

4.22.1. '12.8.98 Requires assistance to settle and sleep at night.... 12.8.98 Haloperidol given at 2330 [hours] as woke from sleep very agitated shaking and crying. Didn't settle for more than a few minutes at a time. Did not seem to be in pain.'

4.22.2. '13.8.98 oromorph at 2100 [hours] Slept well [initialled signature] [paragraph] For Xray tomorrow morning [initialled signature]'

4.22.3. '14.8.98 Same pain in rt[right] leg / ?[query] hip this am. [initialled signature]'

4.22.4. 'Re-admitted 17/8/98'

4.22.5. '17.8.98 Oromorph [Oramorph] 10mg/5ml at present.'

4.22.6. '18.8.98 Now has a syringe driver with 40mgs Diamorphine – comfortable. Daughters stayed. [initialled signature]'

4.22.7. 'Daughters stayed with Gladys [Mrs RICHARDS] overnight. [initialled signature]'

4.22.8. There is no record of continuance of the Nursing Care Plan for 20th and 21st August 1998.

4.22.9. After Mrs RICHARDS had been readmitted to Daedalus ward on 17th August 1998, there is no record between 17th and 21st August 1998 in the patient Nursing Care Plan for 'Nutrition'. On 21st August the record states 'no food taken [initialled signature]'.

4.22.9.1. There is no record that Mrs RICHARDS was offered any fluids.

4.22.10. Similarly, the Nursing Care Plan for 'Constipation' shows no record between 17th and 21st August1998. On 21st August the record states 'BNO [bowels not open] [initialled signature]'

4.22.11. The Nursing Care Plan for 'Personal Hygiene' states:-

4.22.11.1. '18.8.98 Complete Bed Bath given plus oral [Signature] Hygiene [second signature]'

4.22.11.2. '18.8.98 Night: oral care given frequently'

4.22.11.3. '19.8.98 Nightie changed & washed, repositioned. Apparently pain free during care [initialled signature]'

4.22.11.4. It is noted that there is no record of Mrs Richards being attended to for 'Personal Hygiene' on 20th August 1998.

4.22.11.5. '21.9.98 General care and oral hygiene given [initialled signature]'

4.23. The drugs prescribed for Mrs RICHARDS at Gosport War Memorial Hospital from the time of her admission there on 11th August 1998 are described below.

Drugs prescribed for Mrs RICHARDS at Gosport War Memorial Hospital

5. Dr BARTON wrote the following drug prescriptions for Mrs RICHARDS.

5.1. On 11th August 1998:-

5.1.1. Oramorph 10mgs in 5mls to be given orally four hourly. On the Administration Record these doses are recorded as being given—

5.1.1.1. twice on 11th August 1998 (10mg at 1015 [?1215] and 10mg at 1145 [?pm]);

5.1.1.2. once on 12th August (10mg at 0615);

5.1.1.3. once on 13th August (10mg at 2050);

5.1.1.4. once on 14th August (5ml [10mg] at 1150);

5.1.1.5. four times on 17th August (2.5ml [5mg] at 1300, 2.5ml [5mg] at ????[time illegible], 2.5ml [5mg] at1645, and 5ml [10mg] at 2030); and,

5.1.1.6. twice on 18th August 1998 5ml [10mg] at 01230[sic and ? meaning 0030 hours] and 5ml [10mg] at [?]0415).

5.1.2. Diamorphine at a dose range of 20 – 200 mg to be given subcutaneously in 24 hours.

5.1.2.1. None of this diamorphine prescription is recorded on the Administration Record as having been given between 11th – 14th August inclusive.

5.1.3. Hyoscine at a dose range of 200 – 800 mcg [micrograms] to be given subcutaneously in 24 hours.

5.1.3.1. None of this hyoscine prescription is recorded on the Administration Record as having been given between 11th – 14th August inclusive.

5.1.4. Midazolam at a dose range of 20-80 mgs to be given subcutaneously in 24 hours.

5.1.4.1. None of this midazolam prescription is recorded on the Administration Record as having been given between 11th – 14th August inclusive.

5.1.5. Haloperidol 1mg orally twice daily. It is noted that at the top of this prescription chart 'TAKES MEDICINE OFF A SPOON' [sic] is clearly written.

5.1.5.1. She was give 1mg of haloperidol at 1800 hours on 11th August 1998, at 0800 and 2330 hours on 12th August 1998, at 0800 and 1800 hours on 13th August 1998.

5.1.5.2. In addition, on 13th August 1998, Mrs RICHARDS was prescribed haloperidol 2mgs in 1ml to be administered orally as required at a dose of 2.5ml [this figure has been altered and also can be read as 0.5 ml] to be given 'IF NOISY' [sic]. She was given a dose [quantity not stated bearing in mind the altered prescription] at 1300 on 13th August 1998.

5.1.5.3. She was also given 1mg of haloperidol at 0800 hours on 14th and also at 1800 hours on 17 August 1998.

5.1.6. It is noted that, apart from 2330 hours on 12 August 1998, at the above times when Mrs RICHARDS was given haloperidol she was also give 10ml of **Lactulose** [a purgative].

5.2. On 12th August 1998:-

5.2.1. Oramorph 10mgs in 5mls to be given orally in a dose of 2.5 mls four hourly [equivalent to 5mgs of oramorph].

5.2.1.1. Although this drug was apparently not administered its prescription was written up on the 'Regular Prescription' chart but at the side in an ink-drawn box there are the letters PRN [meaning that the prescription is to be administered as required].

5.2.2. Oramorph 10mgs in 5mls to be given orally once at night.

5.2.2.1. Although this drug was apparently not administered its prescription was also written up on the 'Regular Prescription' chart but at the side in an ink-drawn box there are the letters PRN [meaning that the prescription is to be administered as required].

5.3. 18th August 1998:-

5.3.1. Diamorphine at a dose range of 40-200mg to be administered subcutaneously in 24 hours

5.3.2. Haloperidol a dose range of 5-10 mgs to be administered subcutaneously in 24 hours.

5.4. On 18th, 19th, 20th, and 21st August 1998, Mrs RICHARDS was given simultaneously and continuously subcutaneously diamorphine 40mgs, and haloperidol 5mgs, and midazolam 20mgs during each 24 hours.

5.4.1. These drugs are recorded as being administered at the same time of day on each of the four days they were given. They were administered at 1145, 1120, 1045, and 1155 for 18th, 19th, 20th, and 21st August 1998 respectively.

5.4.1.1. All these drugs were administered at the times stated and were signed off by initials as being co-administered by the same person each day. Over the four days of 18th, 19th, 20th, and 21st August 1998, at least three nurses were involved in administering these drugs.

5.4.1.2. According to the prescription charts these drugs were signed for as being administered to Mrs RICHARDS via the syringe driver by Mr Philip BEED on 18th and 19th August 1998, by Ms Margaret COUCHMAN on 20th August 1998, and by Ms Christine JOICE on 21st August 1998.

5.4.2. It is noted that on the 19th, 20th, and 21st August 1998 the drugs midazolam 20mgs, diamorphine 40mgs, and haloperidol 5mgs were also co-administered subcutaneously in 24 hours with 400mcg of hyoscine [this last drug had been

prescribed by Dr BARTON to be given as required on 11th August 1998 but its administration was not commenced until 19th August 1998].

5.4.3. It is also noted that all the drugs for subcutaneous administration were not prescribed at specific starting dosages but each was prescribed for a wide range of dosages and for continuous administration over 24-hour periods.

5.4.3.1. It is not known who selected the dosages to be given.

Death certification and cremation

6. The circumstances of Mrs RICHARDS death have been recorded as follows:

6.1. In a document [Case no. 1630/98] initialled by the Coroner on 24th August 1998 'Reported by Dr BARTON [sic]. Deceased had undergone surgery for a fractured neck of femur. Repaired. Death cert[ificate] issued. [paragraph] THOMAS [sic]

6.2. The cause of death was accepted by the Coroner on 24th August 1998 as being due to:-

6.2.1. '1(a) Bronchopneumonia'.

6.2.2. The death was certified as such by Dr J A BARTON and registered on 24th August 1998.

6.2.3. It is noted that the continuous subcutaneous administration of diamorphine, haloperidol, midazolam, and hyoscine to an elderly person can produce unconsciousness and death from respiratory failure associated with pneumonia.

6.3. The body was cremated.

Conclusions

7. Mrs Gladys Mable RICHARDS died on 21st August 1998 while receiving treatment on Daedalus ward at Gosport War Memorial Hospital.

7.1. Some fours years earlier, on 5th August 1994, Mrs RICHARDS had become resident at the Glen Heathers Nursing Home.

7.2. Mrs RICHARDS's had a confused state that after December 1997 had been aggravated by the loss at the Glen Heathers Nursing Home of her spectacles and both of her hearing aids.

7.3. On 29th July 1998, Mrs RICHARDS developed a fracture of the neck of her right femur [thighbone] and she was transferred from the Glen Heathers Nursing Home to the Royal Hospital Haslar, Gosport.

7.4. Despite her confused state, Mrs RICHARDS was considered by medical staff at the Royal Hospital Haslar to be suitable for implantation of an artificial hip joint. This took place on 30th July 1998.

7.5. On 11th August 1998, and having been seen by a consultant geriatrician, Mrs RICHARDS was transferred for rehabilitation to Daedalus ward at Gosport War Memorial Hospital.

7.6. At that time Dr BARTON recorded that Mrs RICHARDS was not obviously in pain but despite this Dr BARTON prescribed Oramorph [an oral morphine preparation] to be administered orally four hourly.

7.6.1. At that time also Dr BARTON prescribed for Mrs RICHARDS diamorphine, hyoscine, and midazolam. These drugs were to be given subcutaneously and continuously over periods of 24 hours for an undetermined number of days and the exact dosages were to be selected from wide dose ranges.

7.6.2. Also on 11th August 1998, at the end of a short case note, Dr BARTON wrote 'I am happy for nursing staff to confirm death'.

7.6.3. It is noted that although prescribed on the day of her admission to Daedalus ward at Gosport War Memorial Hospital these drugs (diamorphine, hyoscine, and midazolam) were not administered at that time.

7.7. On 13th August 1998, Mrs RICHARDS's artificial hip joint became dislocated.

7.8. The following day, 14th August 1998, although Dr BARTON had recorded 'Is this lady well enough for another surgical procedure?' she arranged for Mrs RICHARDS to be transferred back to Haslar Hospital where the dislocation of the hip was reduced.

7.8.1. It is noted that at the age of 91 years, and despite Dr Barton's comment about Mrs RICHARDS, and her confused mental state, Mrs RICHARDS was considered well enough by the staff at the Royal Hospital Haslar to have two operations on her right hip within about two weeks.

7.9. Three days later, on 17th August 1998, Mrs RICHARDS was returned to the Gosport War Memorial Hospital on a sheet and not on a stretcher. She was very distressed when she reached Daedalus ward.

7.10. There is no evidence that Mrs RICHARDS, although in pain, had any specific life-threatening and terminal illness that was not amenable to treatment and from which she could not be expected to recover.

7.11. Despite this, and on 18th August 1998, Dr BARTON, while knowing of Mrs RICHARDS's sensitivity to oral morphine and midazolam, prescribed diamorphine, midazolam, haloperidol, and hyoscine to be given (from wide dosages ranges) continuously subcutaneously and by a syringe driver over periods of 24 hours for an unlimited period.

7.11.1. Neither midazolam nor haloperidol is licensed for subcutaneous administration.

7.11.2. It is noted, however, that in clinical practice these drugs are administered subcutaneously in the management of distressing symptoms during end-of-life care for cancer.

7.11.3. It is also noted that Mrs RICHARDS was not receiving treatment for cancer.

7.12. There is no evidence that in fulfilling her duty of care Dr BARTON reviewed appropriately Mrs RICHARDS's clinical condition from 18th August 1998 to determine if any reduction in the drug treatment being given was indicated.

7.13. During this period when a syringe driver was being used to administer the subcutaneous drugs, there is no evidence that Mrs RICHARDS was given fluids or food in any appropriate manner.

7.14. There is no evidence that in fulfilling their duty of care Mr Philip BEED, Ms Margaret COUCHMAN and Ms Christine JOICE reviewed appropriately Mrs RICHARDS's clinical condition from 18th August 1998 to determine if any reduction in the drug treatment they were administering was indicated.

7.15. There is, however, indisputable evidence that the subcutaneous administration of drugs by syringe driver continued without modification and during every 24 hours from 18th August 1998 until Mrs RICHARDS died on 21st August 1998.

7.16. Dr Barton recorded that death was due to bronchopneumonia.

7.16.1. It is noted that the continuous subcutaneous administration of diamorphine, haloperidol, midazolam, and hyoscine to an elderly person can produce unconsciousness and death from respiratory failure associated with pneumonia.

My opinion

8. When Mrs RICHARDS was first admitted to Daedalus ward at Gosport War Memorial hospital on 11th August 1998 she was not in pain and had been fully weight bearing walking with the aid of two nurses and a Zimmer frame.

8.1. Despite recording that Mrs RICHARDS was not in pain, on 11th August 1998 Dr BARTON prescribed wide dosage ranges of opiate and sedative drugs to which Mrs RICHARDS was known to be sensitive.

8.1.1. Dr Barton also recorded that 'I am happy for nursing staff to confirm death.' when Mrs RICHARDS had been admitted for rehabilitation and her death was not obviously imminent.

8.2. When, at the age of 91 years, Mrs RICHARDS dislocated her operated hip and despite her confused mental state, she was considered well enough to have a second operation on her right hip within about two weeks of the first operation.

8.3. There is no evidence to show that after her second operation Mrs RICHARDS, although in pain, had any specific life-threatening and terminal illness that was not amenable to treatment and from which she could not be expected to recover.

8.4. It is my opinion, and there is evidence to show, that Mrs RICHARDS was capable of receiving oral medication for the relief of the pain she was experiencing on 17th August 1998.

8.5. Mrs RICHARDS was known by Dr BARTON to be very sensitive to Oramorph, an oral morphine preparation, and to have had a prolonged sedated response to intravenous midazolam.

8.6. Despite this, and from 18th August 1998 for an undetermined and unlimited number of days, Dr BARTON prescription led over 24-hours periods to the continuous subcutaneous administration to Mrs RICHARDS of diamorphine 40mgs, haloperidol 5mgs, and midazolam 20mgs to which was added hyoscine 400mcg from 19th August 1998.

8.7. The administration of these drugs continued on a 24-hours regime without their dosages being modified according to Mrs RICHARDS's response to them and until Mrs RICHARDS died on 21st August 1998.

8.8. There is no record that Mrs RICHARDS was given any food or fluids to sustain her from the 18th August 1998 until she died on 21st August 1998.

8.9. As a result of the continuous subcutaneous administration of the prescribed drugs diamorphine, haloperidol, midazolam, and hyoscine Mrs RICHARDS became unconsciousness and died on 21st August 1998.

8.10. No other event occurred to break the chain of causation and in my opinion Mrs RICHARDS's death was directly attributable to the administration of the drugs she continuously received by syringe driver from 18th August 1998 until her death on 21st August 1998.

8.11. It is my opinion that Mrs Gladys RICHARDS's death occurred earlier than it would have done from natural causes and was the result of the continuous administration of diamorphine, haloperidol, midazolam, and hyoscine which had been prescribed to be administered continuously by a syringe driver for an undetermined number of days.

APPENDIX A

14. I have received and read the following documents:-

14.1. The letter of DCI BURT dated 22nd November 1999 that gave an initial overview of the case.

14.2. The documents in the file DCI BURT presented at our meeting on 28th January 2000 as follows:-

14.2.1. 1) Draft (unsigned) statement (MG11) of Code A
14.2.2. 2) Copy of PEC (NHS) T Health Record (LH/1/C).
14.2.3. 3) Copy of RHH Medical Record (AF/1/C).
14.2.4. 4) Draft (unsigned) statement (MG11) of Gillian MACKENZIE.
14.2.5. 5) Draft (unsigned) statement of Lesley LACK.

14.3. The documents in the file DCI BURT presented at our meeting on 8th March 2000 including those pursuant to my request of 28th January 2000 (documents WX1, WX2, and YZ were forward to me on 9 March 2000) as follows:-

14.3.1.	A	Typed copy of Notes prepared by Mrs LACK and given to Portsmouth Healthcare NHS Trust
14.3.2.	B	Typed copy of additional page of notes which was prepared by Mrs LACK but, apparently, not passed to Portsmouth Healthcare NHS Trust
14.3.3.	C	Typed copy of Notes prepared by Mrs LACK and given to Social Services
14.3.4.	D	Typed copy of comments made by Mrs LACK in respect of letter from Portsmouth Healthcare NHS Trust which represented a response to her Notes of complaint (A)

14.3.5.	E	Typed copy of comments made by Mrs LACK in respect of a Report prepared by Portsmouth Healthcare NHS Trust which resulted in the letter referred to above
14.3.6.	F	As D above but made by Mrs MACKENZIE
14.3.7.	G	As E above but made by Mrs MACKENZIE
14.3.8.	HI	Copy of letter written by Mrs MACKENZIE to DI MORGAN (OIC of initial investigation) plus 5 copies newspaper cuttings
14.3.9.	JK	Copy of Coroner's Officer's Form
14.3.10.	L	Copy of letter from Dr REID to Code A
14.3.11.	M	Copy of Report made by Dr LORD during original investigation
14.3.12.	N	Copy of additional newspaper cutting
14.3.13.	O (1)	Typed copy of signed statement of Code A (RHH)
14.3.14.	O (2)	Typed copy of signed statement of Lesley HUMPHREY (Portsmouth Healthcare NHS Trust)
14.3.15.	O (3)	Copy of signed statement of Lesley LACK
14.3.16.	O (4)	Copy of final draft of Gillian MACKENZIE's statement
14.3.17.	PQ	Copy of schedule of x-ray images (RHH)
14.3.18.	R	Copy of Risk Event Record (Portsmouth Healthcare NHS Trust)
14.3.19.	S (1)	Copy of letter which DCI BURT has sent to Code A (Portsmouth Healthcare NHS Trust) raising various issues
14.3.20.	S (2)	Copy of entries in medical directories 1998/1999 - Dr Jane Ann BARTON
14.3.21.	S (3)	Copy of letter from Mrs MACKENZIE to DCI BURT
14.3.22.	S (4)	Copy of documents which accompanied the two Portsmouth Healthcare NHS Trust x-ray images
14.3.23.	T	Copy of various documents which featured in a Social Services Case Conference stemming from receipt of Mrs LACK's Notes of complaint (C above)
14.3.24.	UV	Copy of Death Certificate - Mrs RICHARDS
14.3.25.	WX1	Witness Statement of Mrs Gillian MACKENZIE dated March 6 2000
14.3.26.	WX2	Copy of letter from Code A to Mrs MACKENZIE with an addendum of five pages being a photocopy from 'Toxic Psychiatry' a book by Code A published by Harper Collins.
14.3.27.	YZ	Two extracts from 'Criminal Law. Diana Rowe. Hodder & Stoughton 1999.'

14.4. On 8th March 2000, in the presence of DCI BURT, I visited:-

14.4.1. the Gosport Memorial Hospital and followed the passageways along which Mrs Richards was conveyed and the ward areas in which she was treated; and,

14.4.2. the Royal Hospital Haslar and followed the passageways along which Mrs Richards was conveyed and the ward area in which she was treated.

14.4.2.1. At the Royal Hospital Haslar, on 8th March 2000, in the presence of DCI BURT, I was also shown twelve (12) radiographs relating to Mrs Richards' treatment there on 12th April 1998, 17th July 1998, 14th August 1998, 29th July 1998, and 31st July 1998.

14.5. In addition I have read the following the documents given to me by DCI BURT on 12th May 2000 consisting of the following which are numbered below as listed in the two containing ring binders:

14.5.1. E 25 Copy of Glen Care Homes file Re: Gladys RICHARDS supplied by Glen Care Homes
14.5.2. E 22 Copy of Hampshire County Council Social Services file Re: Gladys RICHARDS
14.5.3. E23 Copy of Glen Care Homes file Re: Gladys RICHARDS supplied Nursing Homes Inspectorate
14.5.4. E 24 Copy Portsmouth and South East Hampshire Health Authority GP Patient Records of Gladys RICHARDS
14.5.5. D 63 Police letter 090300 to Code A Haslar Hospital with further questions
14.5.6. D 65 Letter 100400 from Code A Haslar including Patient transfer order and further medical records
14.5.7. D 104 Letter 080200 from Mrs. MACKENZIE with notes Re: draft statement
14.5.8. D 108 Portsmouth NHS Trust Dept. of Diagnostic Imaging report folder
14.5.9. D 110 Copy typed Gladys RICHARDS Death Certificate dated 240898

14.6. I have also read the documents given to me by DCI BURT on 19th July 2000, consisting of copies of the statements made by:-

14.6.1. JOICE Christine
14.6.2. GIFFIN Sylvia Roberta
14.6.3. PULFORD Monica Catherine
14.6.4. WALKER Fiona Lorraine
14.6.5. Code A
14.6.6.
14.6.7.
14.6.8. TUBBRITT Anita
14.6.9. COUCHMAN Margaret
14.6.10. Code A
14.6.11.
14.6.12.
14.6.13.
14.6.14.

14.7. I have also read statements, provided on 30th August 2000 by DCI BURT, made by:

14.7.1. Doctor Jane Ann BARTON
14.7.2. Phillip James BEED

14.8. I have also received from DCI BURT on 8th September 2000 and read copies of:-

14.8.1. A letter dated 18th August 2000 from Mrs Gillian MACKENZIE to DCI BURT.

14.8.1.1. Enclosed with this letter was a copy of a letter dated 9th August 2000 from Ms Jill BAKER to Mrs Gillian MACKENZIE to which had been added a petition form.

14.9. A letter dated 21st August 2000 from Mrs Gillian MACKENZIE to DCI BURT.

14.9.1. Enclosed with this letter was a copy of a letter dated 14th December 1998 from Code A, Quality Manager at Portsmouth Healthcare NHS Trust Central Office to Mrs Gillian MACKENZIE. This had enclosed with it a copy of a letter dated 22nd September 1998 from Mr Max MILLETT, Chief Executive of Portsmouth Healthcare NHS Trust.

14.10. Copies of Witness Statements (taken by Mrs S HUTCHINGS who led the initial Internal Inquiry as Investigating Officer of Portsmouth Healthcare NHS Trust) as follows:-

14.10.1. On 3rd September 1998 statement consisting of four pages from Mrs Jenny BREWER – Staff Nurse Daedalus Ward to which is attached an additional statement (three pages) by Staff Nurse Brewer (the first page of this three pages is headed Portsmouth Healthcare NHS Trust and has been signed on page three by S. N J Brewer RGN and dated 9-9-98 (Reference D142)).

14.10.2. On 8th September 1998 statement consisting of five pages from Mr Philip BEED – Clinical Manager Daedalus Ward (Reference D143).

14.10.3. On 9th September 1998 statement consisting of three pages from Ms Christine JOICE – Staff Nurse Daedalus Ward (Reference D144).

14.10.4. On 8th September 1998 statement consisting of two pages from Ms Monica PULFORD – Enrolled Nurse Daedalus Ward (Reference D145).

14.10.5. On 3rd September 1998 statement consisting of four pages from Ms Margaret COUCHMAN – Staff Nurse Daedalus Ward (Reference D146).

14.11. A copy of the National Council for Hospice and Specialist Palliative Care Services paper entitled 'Ethical decision-making in palliative care'.

14.12. On 5th and 6th October 2000 I received from Hampshire Constabulary and subsequently read:-

14.12.1. The records of the interviews conducted with Dr Anthea Everista Geredith LORD on 27th September 2000.

14.12.2. During these interviews Dr LORD produced as listed in the Officer's Report by DC McNally the following documents:-

14.12.2.1. Drug Therapy Guidelines for subcutaneous fluid replacement as approved by the Elderly Medicine and Formulary & Medicines Group of Portsmouth Hospitals and Portsmouth Healthcare updated for 1998.

14.12.2.2. Consultants' Rota for August 1998 of the Department of Medicine for Elderly People (Ref: CI/28.7.98).

14.12.2.3. Memorandum from Code A of Portsmouth Health Care NHS Trust to Dr. LORD dated 17th December 1998 and headed 'Mrs. Richards deceased, Gosport War Memorial Hospital, 21st August, 1998.'

14.12.2.4. Letter from Dr R I REID, Medical Director of Portsmouth Health Care NHS Trust giving approval of study leave for Dr. LORD for the dates of 17/18 August 1998.

14.12.2.5. Consultants' Timetable of the Department of Medicine for Elderly People from 4.5.98 – 8.2.99.

Appendix B

Facts of the environment - obtained from the statements of Mrs RICHARDS's daughters

15. Mrs MACKENZIE is the elder of Mrs RICHARDS's two daughters. It is noted that her sister, Mrs LACK, is a retired Registered General Nurse.

15.1. Mrs LACK retired in 1996 after 41 years continuously in the nursing profession. For 25 years prior to retirement she was involved in the care of elderly people. For 20 years prior to retiring she held supervisory and managerial positions in this field of nursing.

15.2. By July 1998, Mrs RICHARDS had been resident at the Glen Heathers Nursing Home for some four years. She had a past medical history of bilateral deafness for which she required two hearing aids (unfortunately these were lost while she was at the Glen Heathers Nursing Home). She had had operations for the removal of cataracts and required glasses (unfortunately these were also lost at the Glen Heathers Nursing Home).

15.3. Also by July 1998, Mrs RICHARDS had become increasingly forgetful and less able physically. She had had 17 falls documented at the Glen Heathers Nursing Home between 29th January 1998 and 29th July 1998.

15.3.1. During this period Mrs MACKENZIE decided to meet and question her mother's general practitioner, Code A. Mrs MACKENZIE had formed the opinion that the drugs Code A was prescribing could contribute to her mother's confused mental state and deterioration of her physical health. One drug was Trazodone and the other was haloperidol. Following this meeting she sent him a copy of a book entitled *Toxic Psychiatry*.

15.3.2. Dr BASSETT replied, in a hand-written letter, thanking Mrs MACKENZIE and stating '... I have a reputation in Lee [-on-Solent] of being somewhat sparing with 'mood' drugs and especially antibiotics. ... most drugs are prescribed with more caution these days. [paragraph] Hopefully we can continue to keep your Mother's drugs to a minimum!'

15.4. It is convenient to mention here that both Mrs MACKENZIE and Mrs LACK have registered serious concerns about the care given to their mother in the Glen Heathers Nursing Home.

15.4.1. Code A Principal Nursing Home Inspector, Portsmouth & S.E. Hants Health Authority investigated these concerns formally. On 11th August 1998, she made an unannounced visit to the Glen Heathers Nursing Home. She reported, on 26th August 1998, that 'From the written records obtained and discussions held, I can find no evidence to substantiate that Mrs RICHARDS did not receive appropriate care and medication.'

15.4.2. These concerns were discussed further by the Social Services Department at a meeting held on 23rd November 1998 when Mrs LACK was present. The conclusion was that 'There was no evidence of deliberate abuse [of Mrs RICHARDS] although there seemed to be problems of complacency in some of the care practices which needed review.... However, there was no evidence of malpractice by the Home.'

15.5. On 29th July 1998, while in the Glen Heathers Nursing Home, Mrs RICHARDS sustained a fracture of the neck of her right femur (thighbone). According to Mrs

LACK her mother underwent a surgical operation on 30th July 1998 'following a discussion with the consultant who thought my mother should be given the chance to remain ambulant.'

15.6. Mrs LACK has also stated:-

15.6.1. 'My mother received a replacement hip, on her right side, and remained in the Haslar Hospital a further eleven days until Tuesday the 11th August 1998. [paragraph] I visited my mother every day during this period and, in my view, when taking into account the serious injury which she had sustained and the trauma she had suffered, my mother appeared to make a good recovery during this period.'

15.6.2. 'Prior to her discharge, and transfer to the Gosport War Memorial Hospital, my mother was responding to physiotherapy, able to walk a short distance with the aid of a zimmer frame and no longer required a catheter. Her medication had been reduced and she was able to recognise family members and make comments to us which made sense.'

15.6.3. 'She was with encouragement, eating and drinking naturally and as a result the drips, which had facilitated the provision of nourishment after the operation, had been removed.'

15.6.4. 'Significantly, my mother was no longer in need of pain relief. It was quite apparent, to me, that she was free of pain.'

15.6.5. 'Such was the extent of my mother's recovery that it was considered appropriate to discharge her and transfer her to the Gosport War Memorial Hospital where she was admitted to Daedalus Ward on Tuesday the 11th August 1998. This was the first occasion that my mother had been admitted to this particular hospital.'

15.7. On 12th August 1998, the day after her mother's admission to the Gosport War Memorial Hospital, Mrs LACK visited her mother there and has recorded '... I was rather surprised to discover that I could not rouse her [Mrs RICHARDS]. As she was unrousable she could not take nourishment or be kept hydrated. [paragraph] I enquired among the staff and I was told that my mother had been given the morphine based drug 'Oramorph' for pain. This also surprised me. When my mother had been discharged from the Haslar Hospital, the day before, she had not required pain relief for several days. [paragraph] I was distressed to observe my mother's deteriorated condition which significantly contrasted with the level of recovery which had been achieved following treatment at the Haslar hospital during the period after the surgical operation to replace her hip. [paragraph] I was told that my mother had been calling out, showing signs of being anxious, and it was believed that she was suffering pain. They did not investigate the possible cause. I consider it likely that she was in need of the toilet. ... One of the

consequences of being rendered unrousable, by the effects of 'Oramorph', was that no fluids could be given to my mother and this, together with the abandonment of other forms of rehabilitation, would have served to inhibit or prevent the recovery process which had begun prior to her admission to the Gosport War Memorial Hospital.'

15.8. Mrs RICHARDS had a fall on 13th August 1998 (as described above). On the following morning (14th August 1998), Mrs LACK noted that while her mother was being taken to the X-ray department at the Gosport War Memorial Hospital 'She was still deeply under the effects of the 'Oramorph' drug.'

15.9. As described above Mrs RICHARDS was then transferred to the Royal Hospital Haslar for the reduction of her dislocated artificial hip. She was returned to the Gosport War Memorial Hospital on 17th August 1998 having been noted the previous day (16th August) by Mrs LACK [a nurse experienced in the care of elderly people] to be 'easily manageable'.

15.9.1. In accepting that he would transfer Mrs RICHARDS to the Gosport War Memorial Hospital, Dr REID (consultant geriatrician) had stated that '... despite her dementia, she [Mrs RICHARDS] should be given the opportunity to try to re-mobilise.'

15.10. On visiting her mother at the Gosport War Memorial Hospital at about 1215 hours on 17th August 1998, Mrs LACK accompanied by her sister [Mrs MACKENZIE], found her mother to be screaming and in pain. The screaming ceased 'within minutes' when Mrs LACK and a registered general nurse repositioned Mrs Richards.

15.11. Subsequently, the X-ray at the Gosport War Memorial Hospital showed no fresh dislocation of the artificial hip.

15.12. Following this further X-ray, Mrs LACK told Dr BARTON that Haslar Hospital would be prepared to readmit her mother. Dr BARTON is reported to have '... felt that was inappropriate.' Mrs LACK '... considered this was essential so that the 'cause' of my mother's pain could be treated and not simply the pain itself.'

15.12.1. Dr BARTON is stated to have said to Mrs LACK that, '..."It was not appropriate for a 91 year old, who had been through two operations, to go back to Haslar Hospital where she would not survive further surgery." '

15.13. Mrs LACK states that, on 18th August 1998, the Ward Manager [Mr Philip BEED] explained to her and her sister that a syringe driver was going to be used. This was to ensure Mrs RICHARDS 'was pain free at all times' so that she would not suffer when washed, moved, or changed in the event she should become incontinent. Mrs LACK has also described in her contemporaneous notes (as well as in her Witness Statement, see below) that 'A little later Dr BARTON appeared and confirmed that a haematoma

was present and that this [the use of a syringe driver] was the kindest way to treat my mother. She [Dr BARTON] also stated "And the next thing will be a chest infection." '.

15.13.1. In her Witness Statement, Mrs LACK has recorded 'The outcome of the syringe driver was explained to my sister and I fully. Drawing on my experience as a nurse I [Mrs LACK] knew that the continuous use of morphine, as means of relieving her pain, could result in her death. She [Mrs RICHARDS] was, at the time, unconscious from the effects of previous doses of 'Oramorph'.... [paragraph] As result of seeing my mother in such great pain I was becoming quite distressed at this stage. My sister asked the Ward Manager, "Are we talking about euthanasia? It's illegal in this country you know." The Ward Manager replied, "Goodness, no, of course not." I was upset and said, "Just let her be pain free". [paragraph] The syringe driver was applied and my mother was catheterised to ease the nursing of her. She had not had anything by mouth since midday Monday 17th August 1998. [paragraph] A little later Dr BARTON [sic] appeared and confirmed that a haemetoma [sic] was present and that this was the kindest way to treat my mother. She also stated, "And the next thing will be a chest infection." .... [In her witness statement Mrs Mackenzie has stated that ' DR BARTON [sic] then said, "Well, of course, the next thing for you to expect is a chest infection".'][paragraph] I would like to clarify the issue of my 'agreement' to the syringe driver process. It was not a question, in my mind, of 'agreement'. [paragraph] I wanted my mother's pain to be relieved. I did not 'agree' to my mother being simply subjected to a course of pain relief treatment, at the Gosport War Memorial Hospital, which I knew would effectively prevent steps being taken to facilitate her recovery and would result in her death. [paragraph] I also wanted my mother to be transferred back to the Haslar Hospital where she had, on two occasions, undergone operations and recovered well. My mother was not, I knew, terminally ill and, with hindsight, perhaps I should have challenged Dr BARTON [sic] more strongly on this issue. [paragraph] In my severe distress I did not but I do believe that my failure to pursue the point more vigorously should not have prevented Dr BARTON [sic] from initiating an alternative course of action to that which was taken, namely a referral back to the Haslar Hospital where my mother's condition could have been treated and where an offer had already been made to do so. [paragraph] I accept that my mother was unwell and that her physical, reserves had been depleted. However, she had, during the preceding days and weeks, demonstrated great courage and strength. I believe that she should have been given a further chance of recovery especially in the light of the fact that her condition had, it would seem likely, been aggravated by poor quality service and avoidable delay experienced whilst in the hands of those whose responsibly [responsibility] it was to care for her. [paragraph] My mother's bodily strength allowed her to survive a further 4 days using her reserves. She suffered kidney failure on 19th August and no further urine was passed. The same catheter remained in place until

her death. [paragraph] Because the syringe driver was deemed to be essential following the night of several doses of pain relief my mother's condition gradually deteriorated during the next few days, as I knew it inevitably would, and she died on Friday the 21st August 1998.'

15.14. It is noted that Mrs LACK had made contemporaneous hand-written notes comprising five numbered pages. In her Witness Statement she records these '... are in the form of a basic chronology and I incorporated within them a series of questions which focused on particular areas of concern in respect of which I sought an explanation or clarification from the hospital authorities. Following presentation of my notes we were visited on the ward by Code A [sic] on 20.8.98.'

15.14.1. Mrs LACK also made a further one page of contemporaneous hand-written notes. In these she states she was so appalled about her mother's condition, discomfort and severe pain that she visited Haslar Hospital at about lunchtime on 17th August 1998 to ask questions about her mother's condition before she [Mrs RICHARDS] had left the Haslar Hospital ward for her second transfer to Gosport War Memorial Hospital. She learned that, prior to her discharge from Haslar Hospital on 17th August 1998, her mother had been eating, drinking, using a commode and able to stand if aided. Mrs LACK also states in this contemporaneous record that 'On leaving the ward [at Haslar Hospital at about lunchtime on 17th August 1998] I bumped into the Dr [doctor] who had been in casualty theatre for my mothers [sic] second [sic] operation. He was with consultant when all the procedures were explained to me on Friday 14th [August 1998] He said "How's your mother". I explained the current position to him in detail. I told him that she was in severe pain since the transfer which had been undertaken a short time earlier. He said "We've had no referral. Get them to refer her back. We'll see her."

15.15. It is noted that a Discharge Letter from the Royal Hospital Haslar describes Mrs RICHARDS' condition on discharge on 17th August 1998 as "She can, however, mobilise fully weight bearing."

15.16. It is also noted that Mrs LACK has stated that she and her sister were constantly at the Gosport War Memorial Hospital, day and night, from 17th August 1998 until the time their mother died.

15.16.1. Mrs MACKENZIE has stated that 'I stayed with my mother until very late that Tuesday night [18th August 1998]. it was past midnight, in fact, when my son arrived from London. As from the Wednesday night my sister also sat with me all night long and we both remained, continuously, until twenty past nine on the following Friday evening [21st August 1998] when my mother died. During that time Dr Barton [sic] did not visit my mother. I am quite certain about this because our mother was not left alone, in her room, at

any time apart from when she was washed by the nursing staff. Either my sister or I, [sic] was with her throughout.'

15.16.2. Mrs MACKENZIE has also stated that although she did not sign the contemporaneous notes made by Mrs LACK she '... 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.'

15.16.3. Mrs MACKENZIE continues 'It seems to me that she [Mrs RICHARDS] must have had considerable reserves of strength to enable her to survive from Monday until 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.'

Appendix C

Glossary

Acetabulum is the name given to the two deep socket into which the head of the thigh bone (femur) fits at the hip joint.

ADL [activities of daily living] are those physical activities of daily life necessary for normal human functioning and include getting up, washing, dressing, preparing a simple meal, etc.

Analgesia is the relief of pain. This can be achieved by physical means including warmth and comfortable positioning as well as by the use of drugs. The aim is to keep patients pain free with minimal side effects from medication.

Bronchopneumonia is inflammation of the lung usually caused by bacterial infection. Appropriate antibiotic therapy, based on the clinical situation and on microbiological studies, will result in complete recovery in the majority of patients. It can contribute to the cause of death in moribund patients.

Co-codamol is a drug mixture consisting of paracetamol and codeine phosphate, which is used for the relief of mild to moderate pain.

Cyclizine is a drug used to prevent nausea and vomiting, vertigo, and motion sickness.

Dementia is the name given to a condition associated with the acquired loss of intellect, memory, and social functioning.

Diamorphine, also known as heroin, is a powerful opioid analgesic.

Haematoma is an accumulation of blood within the tissues, which clots to form a solid swelling.

Haloperidol, a drug used in the treatment of psychoses including schizophrenia and mania and also for the short-term management of agitation, excitement, and violent or dangerously impulsive behaviour. Dosage for all indications should be individually determined and it is best initiated and titrated under close clinical supervision. For patients who are elderly the normal starting dose should be halved, followed by a gradual titration to achieve optimal response. It is not licensed for subcutaneous administration (see **licensed** below).

Hemiarthroplasty is the surgical remodelling of a part of the hip joint whereby the bone end of the femur is replaced by a metal or plastic device to create a functioning joint.

Hyoscine is a drug used to reduce secretions and it also provides a degree of amnesia and sedation, and has an anti-vomiting effect. Its side effects include drowsiness.

Lactulose is a preparation taken by mouth to relieve constipation.

A **microgram** is one millionth of a gram and is not to be confused with a milligram dosage of a drug, which is one thousand times larger.

Midazolam is a sedative drug about which there have been reports of respiratory depression. It has to be use with caution in elderly people. It is used for intravenous sedative cover for minor surgical procedures. It is also used for sedation by intravenous injection in critically ill patients in intensive care. It can be given intramuscularly. In the management of overdosage special attention should be paid to the respiratory and cardiovascular functions in intensive care. It is not licensed for subcutaneous administration (see **licensed** above).

Morphine is an opioid analgesic used to relieve severe pain.

Oramorph is a drug used in the treatment of chronic pain. It contains morphine and is in the form of a liquid. 10mls of Oramorph at a strength of 10mgs of morphine sulphate in 5mls of liquid is an appropriate first dose to give to a person in severe pain, which had not responded to other less potent, pain relieving drugs.

Respiratory depression is the impairment of breathing by drugs or mechanical means which leads to asphyxia and, if uncorrected, to death.

Subcutaneous means beneath the skin.

A **syringe driver** is a power driven device for pushing the plunger of a syringe forward at an accurately controlled rate. It is an aid to administering medicinal preparations in liquid form over much longer periods than could be achieved by injecting by hand. In this case the syringe driver used was a Sims Graseby MS 26 Daily rate syringe driver which operates over periods of 24-hours.

Tradazone is a drug used in the treatment of depressive illness, particularly when sedation is required.

Unlicensed medicines. In order to ensure that medicines are safe, effective and of suitable quality, they must have a product licence (now called a market authorisation) before being marketed in the United Kingdom. Unlicensed drugs are not licensed for use for any indication or age group. Licensing arrangements constrain pharmaceutical companies but not prescribers. The Medicines Act 1968 and European legislation make provision for doctors to use unlicensed medicines. Individual prescribers of unlicensed medicines, however, are always responsible for ensuring that there is adequate information to support the quality, efficacy, safety and intended use of a drug before using it.

A **Zimmer frame** is a lightweight, but sturdy, frame the patient can use for support to assist safe walking.

APPENDIX D

Texts used for reference have included:

1. Adam J. ABC of palliative care: The last 48 hours. *British Medical Journal* 1997; 315: 1600-1603.

   1.1. This paper is from the widely read, British Medical Journal which is published weekly and received by about 30,000 general practitioners and 45,000 hospital doctors in England and Wales. It records that treatment with opioids (viz. morphine and diamorphine) should be individually tailored, the effect reviewed, and the dose titrated accordingly.

2. *ABPI Compendium of data sheets and summaries of product characteristics 1998-99: with the code of practice for the Pharmaceutical Industry*. Datapharm Publications Limited, 12 Whitehall, London SW1A 2DY.

3. Breggin P R. *Toxic psychiatry. Drugs and electroconvulsive therapy: the truth and the better alternatives.* 1993. HarperCollins Publishers. London. pp. 578.

4. British Medical Association and the Royal Pharmaceutical Society of Great Britain. *British National Formulary*. Number 32 (September 1996). The Pharmaceutical Press. Oxford.

5. *Cecil Textbook of Medicine*. eds. J.C. Bennett & F. Plum. W.B. Saunders Co. 20th Edition. 1996.

6. Letter from Code A and Code A BSc (Hons) Code A, Roche Pharmaceuticals.

6.1. A copy of this letter has already been supplied to the Police and reports that the product licence does not cover the administration of Hypnovel® (midazolam) by subcutaneous injection.

7. Roche Pharmaceuticals. Hypnovel® [midazolam]. Summary of product characteristics.

8. Letter from Code A of Janssen-Cilag Ltd.

8.1. A copy of this letter has already been supplied to the Police and reports that Haldol™ decanoate (haloperidol) is not licensed for subcutaneous use.

9. Letter from Code A of Medical Information and Pharmacovigilance, Norton Pharmaceuticals.

9.1. A copy of this letter has already been supplied to the Police and reports that Serenace™ (haloperidol) ampoules are not licensed for subcutaneous administration.

10. MeReC. Pain control in palliative care. *MeReC Bulletin National Prescribing Centre*. 1996; 7 (7); 25-28.

10.1. MeReC is the abbreviation for the 'Medicines Resource Centre'. This bulletin is sent free to all general practitioners in England and Wales and also to NHS Hospital and Community Pharmacists. The list of those who receive this bulletin is updated every few weeks.

11. Sims Graseby Limited. *MS 16A Syringe Driver. MS 26 Syringe Driver: Instruction manual*. Sims Graseby Limited. 1998.

Appendix E

The writer's qualifications and experience including the management of dying patients

I, Brian Livesley, qualified MB, ChB (Leeds) in 1960.
My principal additional qualifications are MD (London) 1979, FRCP (London) 1989.

Code A

Code A

References as numbered above:

1. Code A

2. Code A

signed .. Code A ... date 10th July 2001

BRIAN LIVESLEY

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KIM/gnt/gosport

18 October 2001

CONFIDENTIAL

Detective Superintendent J James
Hampshire Constabulary
Major Incident Complex
Kingston Crescent
North End
PORTSMOUTH
PO2 8BU

Dear DS James

CONFIDENTIAL MEDICAL REPORT REGARDING MEDICAL MANAGEMENT
OF PATIENTS AT GOSPORT WAR MEMORIAL HOSPITAL

Thank you for asking me to give a report on the management of four patients who died at Gosport War Memorial Hospital. I have based my personal opinion on my qualification as a specialist in geriatric medicine, my 13 years experience as a Consultant Geriatrician with several years experience working at the local hospice.

USE OF OPIOID ANALGESICS

Opioid analgesics are used to relieve moderate to severe pain and also can be used to relieve distressing breathlessness and cough. The use of pain killing drugs in palliative care (ie the active total care of patients whose disease is not responsive to curative treatment) is described in the British National Formulary which is the standard reference work circulated to all doctors in Great Britain. The guidance in the BNF suggests that non-opioid analgesics such as Aspirin or Paracetamol should be used as first line treatment and occasionally non-steroidal anti-inflammatory drugs may help in the control of bone secondaries. If these drugs are inadequate to control the pain of moderate severity then a weak opioid such as Codeine or Dextropropoxyphene should be used either alone or in combination with the simple pain killers in adequate dosage. If these weak opioid preparations are not controlling the pain Morphine is the most useful opioid analgesic and is normally given by mouth as an oral solution every 4 hours, starting with a dose between 5 mg and 20 mg, the aim being to choose the lowest dose which prevents pain. The dose should be adjusted with careful assessment of the pain and use of other drugs should also be considered. If the pain is not well controlled the dose should be increased in a step-wise fashion to control the pain.

Sometimes modified release preparations of Morphine are given twice daily once the required dose of Morphine is established, as this may be more convenient for the patient.

If the patient becomes unable to swallow the equivalent intra-muscular dose of Morphine is half the total 24 hour dose given orally. Diamorphine is preferred for injections over Morphine as it is more soluble and can be given in smaller volume, therefore with less distress to the patient.

Subcutaneous infusions of Diamorphine by syringe driver are standard practise if the patient requires repeated intra-muscular injections, to save the patient unnecessary distress. This is standard treatment in Hospices and other medications can be added to deal with anxiety, agitation and nausea as they can safely be mixed with Diamorphine (such as Haloperidol, Cyclizine and Midazolam). The other indications for use of the parenteral route are when the patient is unable to take medicines by mouth due to upper gastro-intestinal problems and occasionally if the patient does not wish to take regular medication by mouth.

The BNF has a table showing the equivalent doses of oral Morphine and parenteral Diamorphine for intramuscular injection or subcutaneous infusion as a guide to the dosage when switching from the oral to the injection route, eg 10 mg of oral Morphine 4 hourly is equivalent to 20 mg of Diamorphine by a subcutaneous infusion every 24 hours, and 100 mg oral Morphine 4 hourly is equivalent to 240 mg of Diamorphine subcutaneously every 24 hours.

SUMMARY

It is clear from the above that a doctor trying to control pain should first start the patient on a non-opioid analgesic, move on to a weak opioid analgesic if the pain is not controlled, consider changing the patient to regular oral Morphine if the pain remains poorly controlled and only start parenteral Diamorphine if the patient is unable (or unwilling) to take Morphine by mouth and would otherwise need regular painful injections of Diamorphine to try and control the pain. There is clear guidance on the dose of Morphine to use in a syringe driver when transferring from oral Morphine to the subcutaneous route. Finally the dose of Morphine or Diamorphine should be reviewed regularly and only increased if the symptom of pain is not adequately controlled.

CASE NOTE REVIEWS

1 ARTHUR CUNNINGHAM

Mr Cunningham was known to suffer with depression, Parkinson's disease and cognitive impairment with poor short term memory. He suffered with long standing low back pain following a spinal injury sustained in the Second World War which required a spinal fusion. He suffered with hypertension and non insulin diabetes mellitus, had a previous right renal stone removed, and bladder stones, and had a previous trans-urethral prostatectomy. Myelodysplasia had been diagnosed (a bone marrow problem affecting the production of the blood constituents). Mr Cunningham had a one month admission under the care of Dr Banks for depression in July and August 1998.

Mr Cunningham was admitted by Dr Lord, Consultant Geriatrician from the Dolphin Day Hospital to Dryad Ward at Gosport War Memorial Hospital on 21 09 1998 because of a large necrotic sacral ulcer with a necrotic area over the left outer aspect of the ankle (these are signs of pressure sores). Dr Lord's intention was to give more aggressive treatment to the sacral ulcer. He was seen by Dr Barton. A dose of 2.5 mg to 10 mg of Oromorph 4 hourly was prescribed and he was given 5 mg prior to his sacral wound dressing at 1450 and a further dose of 10 mg at 2015. Diamorphine via a syringe driver was prescribed at a dose of 20 mg to 200 mg in 24 hours and this was commenced at a dose of 20 mg for 24 hours with Midazolam at 2300 on 21 09 1998. Dr Barton reviewed the patient on 23 September when he was said to be "chesty", Hyoscine was added to the syringe driver and the dose of Midazolam was increased. The patient was noted to be in some discomfort when moved on that day and the next day he was said to be "in pain" and the Diamorphine dose was increased to 40 mg for 24 hours, then 60 mg the following day and 80 mg on the 26 September, there being no further comments as to the patient's condition. The dose of Midazolam and Hyoscine was also increased. The patient died at 2315 on 26 09 1998.

Comments

All the prescriptions for opiod analgesia are written in the same hand, and I assume they are Dr Barton's prescriptions although the signature is not decipherable. Morphine was started without any attempts to control the pain with less potent drugs. There was no clear reason why the syringe driver needed to be started as the patient had only received two doses of oral Morphine, the 24 hour dose requirement of Diamorphine could not therefore be established. The dose of Diamorphine prescribed gave a tenfold range from 20 mg to 200 mg in 24 hours which is an unusually large dose range in my experience. The patient was reviewed by Dr Barton on at least one occasion and the patient was noted to be in some discomfort when moved. The dose was therefore appropriately increased to 40 mg per 24 hours but there are no further comments as to why the dose needed to be progressively increased thereafter. In my view Morphine was started prematurely, the switch to a syringe driver was made without any clear reason and the dose was increased without any clear indication.

2 ALICE WILKIE

Miss Wilkie was known to suffer with severe dementia, depression and rectal bleeding attributed to piles. She had been admitted to Philip Ward with a urinary tract infection and immobility under the care of Dr Lord and a decision was made to transfer her to Daedalus ward at Gosport War Memorial Hospital for a few weeks observation prior to a decision on placement. She was transferred on the 6 August and was seen by Dr Peters. The nurses recorded that the patient was complaining of pain but it was difficult to establish the nature or site of this pain. Diamorphine was prescribed on 20 08 1998 in a dose of 20 mg to 200 mg per 24 hours and the signature is identical to that on Mr Cunningham's case which I assume is Dr Barton's. A dose of 30 mg was given on 20 08 1998 with Midazolam and an entry in the notes, again apparently by Dr Barton, comments on a "marked deterioration over last few days". The patient was given another 30 mg of Diamorphine on 21 08 1998 and died that day at 1830. The patient was said to be comfortable and pain free by the nursing staff on the final day.

Comments

There was no clear indication for an opiod analgesic to be prescribed, and no simple analgesics were given and there was no documented attempt to establish the nature of her pain. In my view the dose of Diamorphine that was prescribed at 30 mg initially was excessive and there is no evidence that the dose was reviewed prior to her death. Again the Diamorphine prescription gave a tenfold range from 20 mg to 200 mg in 24 hours.

3 ROBERT WILSON

Code A

hypothyroidism and heart failure. He was originally admitted via Accident & Emergency on the 22 September with a fractured left humerus and transferred to Dickens Ward under the care of Dr Lord. His fracture was managed conservatively. In view of the severe pain he received several doses of Morphine and was prescribed regular Paracetamol.

He was reviewed by Code A Consultant Psychogeriatrician, who felt he had an early dementia and depression and recommended an anti-depressant. He was also noted to have poor nutrition.

Dr Lord made a decision to transfer Mr Wilson for a "short spell to a long term NHS bed" with the aim of controlling his pain and presumably to try to rehabilitate him. He was accordingly moved to Dryad ward at Gosport War Memorial Hospital on the 14 October. The transfer letter from Dickens

ward shows that he was still " in a lot of pain in arm".

The prescription appears to have been written by Dr Barton once again. Paracetamol was prescribed but never given by the nursing staff. Oramorph was prescribed 10 mg 4 hourly and 20 mg nocte commencing on 15 10 1998 and the night time dose was given with "good effect" as judged by the nursing staff. The nursing report goes on to say that Mr Wilson had become "chesty" and had "difficulty in swallowing medications". Oramorph was also prescribed 5 mg to 10 mg as required 4 hourly and four doses were given, suggesting Mr Wilson was in persisting pain. on 16 10 1998 the patient was seen by Dr Knapman. The patient was said to be unwell, breathless, unresponsive with gross swelling of the arms and legs. No ECG or oxygen saturation was recorded but the patient's dose of Frusemide (a diuretic) was increased, so I assume the patient was thought to have worsening heart failure. The nurses report a "very bubbly chest". A Diamorphine/Midazolam subcutaneous infusion was prescribed on 16 10 1998 again, in Dr Barton's handwriting, the dose range from 20 mg to 200 mg in 24 hours. 20 mg of Diamorphine was given on 16 10 1998 and the nurses commented later that the "patient appears comfortable", the dose was increased to 40 mg the next day when copious secretions were suctioned from Mr Wilson's chest. On 18 10 1998 the patient was seen by Dr Peters and the dose of Diamorphine was increased to 60 mg in 24 hours and Midazolam and Hyoscine were added. The patient died on 18 10 1998 at 2340 hours.

Comments

Mr Wilson was clearly in pain from his fractured arm at the time of transfer to Dryad ward. Simple analgesia was prescribed but never given (there was an entry earlier in the episode of care that Mr Wilson had refused Paracetamol). No other analgesia was tried prior to starting morphine. Mr Wilson had difficulty in swallowing medication. The Oramorphine was converted to subcutaneous Diamorphine in appropriate dose as judged by the BNF guidelines. The patient was reviewed by a doctor prior to the final increase in Diamorphine. Once again the Diamorphine prescription had a tenfold dose range as prescribed.

It is clear that Mr Wilson's condition suddenly deteriorated probably due to a combination of worsening heart failure and terminal bronchopneumonia and I consider that the palliative care given was appropriate. A Do Not Resuscitate decision had been made by Dr Lord on 29 09 1998.

4 EVA PAGE

Mrs Page was known to suffer with hypertension, ischaemic heart disease with heart failure and paroxysmal atrial fibrillation, depression, episodic confusion and had sustained a minor stroke in the past. She was admitted on 06 02 1998 to Victory Ward with nausea, anorexia and dehydration and had recently been treated for depression. She was transferred to Charles Ward on 19 02 1998 and had been noted to have a 5 cm mass on chest

x-ray compatible with a lung cancer. She was transferred to Dryad ward, Gosport Memorial Hospital on 27 02 1998 for palliative care. On arrival she was noted to be calling out frequently, and anxious. She was prescribed Thioridazine (a tranquilliser) but this did not relieve her distress and she was prescribed Oramorph 5 mg to 10 mg as required 4 hourly, I believe, by Dr Barton. The nurses report "no relief". She was seen by another doctor who was not named in the nursing record who prescribed regular Thioridazine and Heminevrin at night. On 01 03 1998 it is recorded that Mrs Page "spat out medication", on 02 03 1998 there was an entry, I believe by Dr Barton, stating "no improvement on major tranquillisers. I suggest adequate opioids to control fear and pain". He prescribed a Fentanyl patch 25 mg (another opioid which can be given as a skin patch) and the prescription was countersigned by Dr Lord, I believe. The nursing records state she was "very distressed", she was reviewed by Dr Barton and Diamorphine 5 mg intramuscularly was given. She was then seen by Dr Lord and a further dose of intramuscular 5 mg Diamorphine was given. On 03 03 1998 a syringe driver was started, prescribed, I believe, by Dr Barton, at a dose of 20 mg to 200 mg in 24 hours. The initial dose given was 20 mg of Diamorphine with Midazolam which was started at 1050. The nurses record "rapid deterioration ..... right side flaccid" . The patient died at 2130 that evening.

Comments

Mrs Page had a clinical diagnosis of lung cancer. There was no documentation of any symptoms relevant to this and no evidence of metastatic disease. There was no documentation of any pain experienced by the patient. When she was transferred to Dryad Ward most medication was stopped but she required sedative medication because of her distress and anxiety. No psychogeriatric advice was taken regarding her symptom control and she was started on opioid analgesia, in my view, inappropriately. Following her spitting out of medication she was given a topical form of an opioid analgesic (Fentanyl). A decision was taken to start a syringe driver because of her distress. This included Midazolam which would have helped her agitation and anxiety.

The prescription for subcutaneous Diamorphine infusion again showed a tenfold range from 20 mg to 200 mg. It was clear that her physical condition deteriorated rapidly and I suspect she may have had a stroke from the description of the nursing staff shortly prior to death.

CONCLUSIONS

I felt that the nursing records at Gosport War Memorial Hospital were comprehensive on the whole. The reason for starting opioid therapy was not apparent in several of the cases concerned. There had been no mention of any pain, shortness of breath or cough requiring relief. In several of the cases concerned oral morphine was not given for long enough to ascertain the patient's dose requirements, the reason for switching to parenteral Diamorphine via subcutaneous infusion was not documented and the prescription of a tenfold range (20 mg to 200 mg) of

Diamorphine on the "as required" section of the drug chart is, in my view, unacceptable. In my view the dose of Diamorphine should be prescribed on a regular basis and reviewed regularly by medical staff in conjunction with the nursing team. There was little indication why the dose of Diamorphine was increased in several of the cases and the dose appears to have been increased without the input of medical staff on several occasions.

Specimen signatures of Dr Lord and Dr Barton are necessary to confirm the identity of the prescribers and doctors making entries into the clinical notes.

I believe that the use of Diamorphine as described in these four cases suggest that the prescriber did not comply with standard practise. There was no involvement, as far as I could tell, from a palliative care team or specialist nurse advising on pain control. I believe these two issues require further consideration by the Hospital Trust.

I trust this report contains all the essential information you require. Please let me know if you wish me to give any further comment.

Yours sincerely

Code A

DR K I MUNDY FRCP
CONSULTANT PHYSICIAN AND GERIATRICIAN

In reply please quote 2000/2047

Please address your reply to the Committee Section, FPD
Fax Code A

25 February 2002

Special Delivery

Dr J A Barton

Code A

GENERAL MEDICAL COUNCIL

Protecting patients, guiding doctors

Dear Dr Barton

I am writing to notify you that a person referred to in rule 4(1) ("the medical screener") of the General Medical Council Preliminary Proceedings Committee and Professional Conduct Committee (Procedure) Rules 1998[(a)] has considered information received by the GMC about your conduct.

Copies of the information received are attached and listed at page 2 of the enclosed bundle of papers.

The screener, exercising his powers under rule 4 of the General Medical Council (Interim Orders Committee)(Procedure) Rules 2000, considers that the circumstances are such that you should be invited to appear before the Interim Orders Committee in order that it may consider whether it is necessary for the protection of the members of the public, or is otherwise in the public interest, or in your own interests, that an interim order should be made suspending your registration, or imposing conditions upon your registration, for a period not exceeding eighteen months, in exercise of their powers under section 41A(1) of the Medical Act 1983 as amended.

The screener has reached this decision after considering that the information received from Hampshire Constabulary is of such a nature that it may be both in the public interest and in your own interest that your registration to be restricted whilst those matters are resolved.

You are invited to appear before the Committee at 09.30 on 21 March 2002 at the Council's offices at 44 Hallam Street, London, W1, if you so wish, to address the Committee on whether such an order should be made in your case. You may, if you wish, be represented by Counsel, or a solicitor, or by a member of your family, or by a representative of any professional organisation of which you may be a member. You may also be accompanied by not more than one medical adviser. The Committee is, however, empowered to make an order in relation to your registration irrespective of whether or not you are present or represented.

178 Great Portland Street London W1W 5JE Telephone 020 7580 7642 Fax 020 7915 3641
email gmc@gmc-uk.org www.gmc-uk.org

You are invited to submit observations on the case in writing. Any observations will be circulated to the IOC before they consider your case. Your observations should be marked for the attention of Adam Elliott, Committee Section (fax no Code A Code A

You are invited to state in writing whether you propose to attend the meeting, whether you will be represented or accompanied as indicated above, and if so, by whom. The Interim Orders Committee normally meets in private but you may if you wish, under the provisions of rule 9 of the Procedure Rules, direct that the meeting should be held in public. If you wish for the meeting to be held in public could you please notify Adam Elliott, Committee Section (fax number as above), as soon as possible.

The GMC is under a statutory duty to publish the outcome of IOC hearings. It is our usual practice to do so by placing the outcomes of hearings on our website. If you do not attend the hearing could you please supply Adam Elliott (fax number as above) with a telephone or fax number where you can be contacted on the day of the hearing so we can let you know of the decision before placing the information on our website. If you do not provide such a contact number, or we are unable to contact you, the outcome of the hearing will still be published.

I enclose copies of the relevant provisions of the Medical Act, the Interim Orders Committee Procedure Rules, a paper about our fitness to practice procedures and a paper about the procedures of the Interim Orders Committee.

In accordance with Section 35A(2) of the Medical Act 1983 (as amended), you are required to inform us, within 7 days of receipt of this letter, of the name and address of all of your current employers including any locum agencies with whom you are registered, and the hospital or surgery at which you currently work. If you engage in any non-NHS work, you are also required to notify us, within the same period of time, of the name of the organisation or hospital by which you are employed, or have any working arrangements. Please return this information in the envelope provided.

If you intend to consult your medical defence society, or to take other legal advice, you should do so without delay. The documents enclosed with this letter may contain confidential information. This material is sent to you solely to enable you to prepare for this hearing. The documents must not be disclosed to anyone else, except for the purpose of helping you to prepare your defence.

Please will you write personally to acknowledge receipt of this letter quoting the reference above.

Yours sincerely

Code A

Your ref: RIR/cmp

Our ref: 2000/2047

25 February 2002

First Class Post

Dr R I Reid
Code A
Portsmouth Healthcare NHS Trust
Queen Alexandra Hospital
Cosham
Portsmouth PO6 3LY

GENERAL MEDICAL COUNCIL

Protecting patients, guiding doctors

Dear Dr Reid

Dr Jane Barton

Further to our previous communication, I am writing to notify you that on 21 March 2002, in accordance with Section 41A(2) of the Medical Act 1983 as amended, the Council's Interim Orders Committee (IOC) is scheduled to consider information provided by Hampshire Constabulary concerning the deaths of 5 patients at Gosport War Memorial Hospital. The IOC has the power to suspend or impose interim conditions on Dr Barton's registration until such time as the issues raised by this information are resolved.

We shall inform you of the Committee's decisions once known. If, in the meantime, I can be of any further assistance, please don't hesitate to contact me.

Yours sincerely

Code A

178 Great Portland Street London W1W 5JE Telephone 020 7580 7642 Fax 020 7915 3641
email gmc@gmc-uk.org www.gmc-uk.org

Your ref: PO/JD/021302jb.doc

Our ref: 2000/2047

25 February 2002

First Class Post

Code A
Isle of Wight, Portsmouth &
South East Hants Health Authority
Finchdean House
Milton Road
Portsmouth PO3 6DP

GENERAL MEDICAL COUNCIL
Protecting patients, guiding doctors

Dear Code A

Dr Jane Barton

Further to our previous communication, I am writing to notify you that on 21 March 2002, in accordance with Section 41A(2) of the Medical Act 1983 as amended, the Council's Interim Orders Committee (IOC) is scheduled to consider information provided by Hampshire Constabulary concerning the deaths of 5 patients at Gosport War Memorial Hospital. The IOC has the power to suspend or impose interim conditions on Dr Barton's registration until such time as the issues raised by this information are resolved.

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Code A

178 Great Portland Street London W1W 5JE Telephone 020 7580 7642 Fax 020 7915 3641
email gmc@gmc-uk.org www.gmc-uk.org

IOC REFERRALS

DOCTORS FULL NAME : Jane Ann BARTON
FPD REFERENCE : 2000/2047
CASE WORKER : Code A
DOCTOR'S PLACE OF PRACTICE: Southampton area – currently practising with locally agreed restrictions
DOCTORS SPECIALITY : General Practice
DATE OF REFERRAL TO IOC : 14/02/02
REFERRED BY : Code A
MEMBER(S) THAT HAVE SEEN CASE: Code A and IOC panel on 21/06/01
SUMMARY OF ALLEGATIONS :

Code A is a General Practitioner who was also engaged by Portsmouth Healthcare NHS Trust as a visiting clinical assistant at Gosport War Memorial Hospital. Concerns about Dr Barton's use of pain relieving drugs became the subject of a police investigation into the unlawful killing of elderly patients at Gosport War Memorial Hospital.

The case was considered by the IOC in June 2001. At that time the police investigation was at an early stage and only 1 death was being investigated. The information available to the Committee was therefore limited. The Committee decided to make no order.

The police investigation is now over. No charges were brought but the police case papers were forwarded to the GMC for consideration. The information now in our possession refers to 5 deaths, all of which are covered by 'expert' reports. The papers have been reviewed by the screener who considers that the new information is of such a nature that the case warrants the referral back to the IOC.

21-FEB-2002 14:47 FROM Code A IOWP&SEH HA CE OFFICE TO Code A P.01

Isle of Wight, Portsmouth and South East Hampshire
Health Authority

Finchdean House
Milton Road
Portsmouth PO3 6DP

Switchboard: 023 9283 8340
Direct Dial: Code A

From Fax Number: Code A

PRIVATE & CONFIDENTIAL

FAX TRANSMISSION

TO:	Code A		
TO FAX NUMBER:			DATE: 21 February 2002
FROM:			PAGE 1 OF 2

If you do not receive all pages of this fax, please phone Code A immediately
Thank you

MESSAGE:

Dear Code A

Following our recent telephone conversation please find attached letter to Dr Barton as promised.

Regards

Code A

Case closure form

Please complete this form as soon as you close a enquiry/complaint

Case number	2000 / 2047 / 03

	Please tick	Notes
Are there any other ongoing complaints about this doctor(s) which are to be kept open?	◉ Yes ○ No	If yes give complaint number(s): 2000/2047/02; 2002/1345
Have you made sure all SDFs and/or other appropriate checklists have been completed?	◉ Yes ○ No	
Have you made sure FPD is correctly updated?	◉ Yes ○ No	
Have you checked that all FPD alarms on IRS been removed or updated appropriately?	◉ Yes ○ No	
Have all appropriate parties been informed?	◉ Yes ○ No	
Have all original documents been returned to their owners, where this is appropriate?	○ Yes ○ No	n/a
Have you checked the registration record (IRS) has been amended to show correct status (e.g. erased)?	○ Yes ○ No	n/a
Have you made sure the file cover is in reasonable condition (legible name and reference, not about to fall apart)?	◉ Yes ○ No	Even if the file is for destruction, you should still ensure the name and reference are legible unless you are going to destroy it now yourself

Your name: Code A

Date (dd/mm/yyyy): 09/07/2002

Now please print this form, sign it and attach … en press submit.

Submit Reset

Signed: Code A

Screening decision form
Section 5
SPM or SDP

Completed by the Office (categorise) and the Medical Screener (judgement)

FPD complaint reference 2000 2047 03 Date 05 06 02 (D D M M Y Y)

Dr's name BARTON Reg no **Code A** Complainant

Q5.5 MUST BE COMPLETED BY THE MEDICAL SCREENER FOR ALL CASES UNLESS AN EARLIER REFERRAL TO IOC WAS AGREED

Q5.1 Did the events complained take place after 1 July 1997?

Yes ☐ *Could be spm or sdp*
No ☐ *Cannot be sdp may be spm*
Combination ☐ *Could be spm or sdp*

→Q5.2a

Q5.2a Does the complaint fall into any of the following categories which raise an issue of spm?

SPM
Tick all that apply

	Office	Medical Screener	
Sexual assault or indecency			
Indecent behaviour	☐	☐	
Indecent assault	☐	☐	
Rape/attempted rape	☐	☐	
Female circumcision	☐	☐	
Violence			
Assault/breach of the peace	☐	☐	
Attempted murder	☐	☐	
Firearms offences	☐	☐	
Murder/manslaughter	☐	☐	
Robbery	☐	☐	
Dysfunctional conduct			→Q5.5
Improper sexual/emotional relationship	☐	☐	
Offences under the Abortion Act	☐	☐	
Persisting in practice when carrier of an infectious disease	☐	☐	
Controlled substance offences	☐	☐	
Dishonesty			
False claims to qualifications/experience	☐	☐	
Financial fraud/deception	☐	☐	
Forgery/improper alteration of documents	☐	☐	
Research misconduct	☐	☐	
Theft	☐	☐	
None of the above apply	☐	☑	→ Q5.2b

Q5.2b The following categories might raise an issue of spm and/or suggest there may have been sdp.

Office: Tick all categories that apply
Medical Screener: Please make a judgement for each category ticked by the office,
And any others that you judge appropriate.

- SPM is action or inaction by a doctor of a serious kind of which no doctor of reasonable skill and exercising reasonable care would be responsible. The weight of the evidence and the intent of the doctor should not be taken into account when reaching a decision on whether a question of SPM is raised at this stage
- SDP is normally indicated by a pattern of serious failure to comply with relevant professional Standards. When deciding whether a complaint raises an issue of sdp, evidence before 1 July 1997 cannot be taken into account.

Tick all that apply

	Office	Medical Screener	
Dysfunctional conduct			
Abusive behaviour	☐	☐	
Driving under the influence of alcohol/drugs	☐	☐	
Failure to report dysfunctional colleague(s)	☐	☐	
Soliciting money from patients	☐	☐	
Dishonesty			
False certifications/false reporting	☐	☐	
False claims about effectiveness of treatment	☐	☐	
Sub-standard clinical practice and care			
Communication skills	☐	☐	
Confidentiality issues	☐	☐	
Consent issues	☐	☐	
Inadequate practice arrangements	☐	☐	
Inappropriate/irresponsible prescribing	☑	☑	
Practising beyond limits of skills or knowledge	☐	☐	→Q5.2c
Relations with colleagues	☐	☐	
Relations with patients	☐	☐	
Sub-standard treatment	☑	☑	
Other complaints and enquiries			
Administration of nursing/residential homes	☐	☐	
Advertising	☐	☐	
Canvassing of patients/other practice disputes	☐	☐	
Medical reports/records issues	☐	☐	
Removal from practice list	☐	☐	
Treatment under the Mental Health Act	☐	☐	
Other *(please specify)*	☐	☐	
.....			
.....			
.....			
None of the above apply	☐	☐	→ Q5.2c

To be completed by the Medical Screener

Q5.2c The following criteria may assist in assessing whether the conduct or performance procedures are appropriate. This list is not exhaustive but may be an indicator of sdp.

Tick all that apply

A doctor who has a tendency to use inappropriate techniques	☐	Q5.3
A lack of basic knowledge/poor judgement	☐	
A lack of familiarity with basic clinical/administrative procedures	☐	
A doctor who has failed to keep up to date records	☐	
A lack of insight	☐	

A range of inadequacies:		
Outdated techniques	☐	Q5.3
Attitude	☐	
Inadequate practice arrangements	☐	
Concerns over referral rates	☐	
Poor record keeping	☐	
Inadequate hygiene arrangements	☐	
Other (*please specify)*	☐	

Q.5.3 On the basis of information, in your opinion does the case raise an issue of spm or is there a suggestion there may have been sdp?

spm	☑ Refer to next PPC	→Q5.5
sdp	☐ Send performance Rule 5 letter	→Q5.5
both	☐	→Q5.5
cannot judge	☐	→Q5.4

Please give brief reasons for your decision Notified of complaint (on e-log sent) views invited from practitioner & PCT.

.....

To be completed by the Medical Screener

Q5.4 If you cannot make a decision on the information currently available, from whom is further information required and **what** is required?

Tick all that apply		*Write a brief note*	
Complainant	☐	.....	→ *Q5.5 then Sign. date and return to the office (to seek further information)*
HA/NHS Trust/PCT	☐	.....	
GMC' solicitor's investigation	☐	.....	
Other (please specify)		.....	
.....	☐	.....	
.....	☐	.....	

Signed (Medical Screener) .....

Date .....

Q5.5 Regardless of the state of the information, in your opinion does there appear to be a current or imminent risk to the public?

Yes ☐ → *Q5.6 and SDF 4*
No ☐ → *Q5.6*
Already referred, N/A ☐ → *Q5.6*

Q5.6 Based on the information available to you at this stage, please rate the seriousness of the doctor's alleged behaviour/conduct.

Tick one option only

a. Very serious ☑
b. Quite serious ☐
c. Not very serious ☐
d. Not at all serious ☐

→ *Q5.7*

Q5.7 Do any of the following exceptions apply?

If multiple options apply, only tick the box for the main option

a. Doctor is terminally ill and not in active practice ☐
b. There is no tenable basis for taking action because:
   i. The complainant has declined reasonable requests for further information ☐
   ii. There is no probative evidence to support the allegation(s) nor any prospect of obtaining any ☑
   iii. The complaint is self-evidently untrue/irrational ☐
c. None of the above apply ☑

→ *Q5.8*

Declaration

Q5.8a In my view this case raises:

Tick one box only

a. An issue(s) of spm and should be referred to the next available PPC ☐
b. An issue(s) of sdp and a performance Rule 5 letter should be sent ☐

→ *Sign, date below and return to the office*

c. Issues of both spm and sdp ☐ → *Q5.8b*
d. No issues of spm or sdp ☐ → *Q5.8c*

Q5.8b In my opinion this case should be considered in accordance with:

Tick one box only

a. The conduct procedures ☐ → Refer to next PPC
b. The performance procedures ☐ → Performance R5 letter

Signed (Medical Screener) **Code A**

Date 16/8/02

PTO 5.8c

OR

Q5.8c In my view this case cannot proceed under either the conduct or performance procedures for the reasons as shown at Q5.7 ☑ *Sign, date and return to the office*

Signed (Medical Screener) ..... Code A

Date 27/6/02

To be completed by the Lay Screener

Q5.9a Do you agree with the Medical Screener's decision at Q5.8?

Yes ☑ → *Sign, date and return to the office*

No ☐ → Q5.9b

Signed (Lay Screener) ..... Code A

Date 4/7/02

Q5.9b Please state briefly why you do not agree with the Medical Screener's decision at Q5.8

.....

.....

.....

.....

..... } *Sign, date and return to the office*

Signed (Lay Screener) .....

Date .....

Code A

14/Feb/02

Dear Sir,

I wish to make a formal complaint against a Dr. Jane Barton with respect to the medication given to my mother, a Mrs. Edna Irene Purnell and the reasons for administering such drugs whilst she was a patient under her care in Dryad Ward at the War Memorial hospital here in Gosport, Hampshire.

The basic outline of this complaint centres primarily on the following.

1. Why did Dr. Barton write on my mother's medical notes (see section 4 page 4 of the enclosed photo copy of W.M.H. records) that she was to quote her exact words 'Happy for the nursing staff to confirm my mother's death'. This was on the 20/11/98 and then repeating the same again on 28/11/98 (see section 4 page 5). My mother did not die until the 3/12/98.
2. Why the medication my mother was taking for oedema at the Royal Haslar hospital was stopped immediately after she was transferred to the W.M.H.
3. Why in view of the fact that during the last week (5/11/98 to 11/11/98) whilst my mother was a patient at the Royal Haslar hospital she did not require any painkilling medication and yet the day after being admitted to the War Memorial hospital (here-after the WMH) date being the 12/11/98 she was given 20mg of oramorph in a space of only 8½ hours and was continually given various amounts daily (apart from the 17/11/98) of morphine right up to the time of her death on 3/12/98. As for the 17th November 1998 my mother was given 100mg of Diclofenac instead. Not written up on her medical records that is the actual drug chart (see enclosed WMH records pertaining to medication administered to my mother)

The WMH states that the reason for giving my mother oramorph from and on the 12/11/98 (first complete day that she a patient in this hospital) is that her bedsores (then only her heels) were causing her great pain. Then if this was the case I have to ask the obviuos question which is why didn't my mother need some kind of pain killing medication the day previous to being transferred to this hospital or even the week previous whilst she was still a patient in the Royal Haslar hospital.

No way could bedsores deteriorate to that extent in just 24 hours. If the bedsores were causing some degree of pain then surely R.H hospital would have been giving her pain killing medication also further to that surely the WMH could have treated my mother's pain with something less drastic than giving her morphine.

Anyway everything of importance without suffocating you with letters and other documents I have enclosed for you to read. Quite a fair amount to wade through, but still there is no hurry. I would though greatly appreciate it when you have the time to if you could take a look through what I have sent you.

Thanking you for all your help.

Yours sincerely,

Code A

M. E. Wilson. (mr)

Phone Number Code A

Code A

14/Feb/02

Dear Sirs,

This letter is to confirm in writing the following.

1. I give my permission that all correspondence that I send to the G.M.C. with regards to my complaint can be disclosed to a Dr. J.Barton.

2. I am prepared to be a witness at any enquiry that the G.M.C. cares to arrange whether it be in public or otherwise providing it is relevant to my complaint.

3. I am willing to supply verbally or written a sworn statement to support my complaint.

Yours sincerely,

Code A

M.E.Wilson (mr)

Phone Number Code A

THIS LETTER WAS SENT TO A DR. REID CONSULTATAN GERIATRICIAN Q.A. HOSPITAL COSHAM PORTSMOUTH
AND A COPY OF IT TO MAX MILLETT
OF THE PORTSMOUTH N.H.S. TRUST.

27/11/98

Dear Sir,

Well where do I start this letter, with an apology perhaps for the poor presentation (assuming that is you have seen it) of the chronological list of events pertaining to my mother's stay in hospital. It was written in haste, hence the standard of the grammar. So taking this into account, although no doubt one could pick holes in the revised one, I have enclosed a copy for you and I hope when it is convenient to do so that you will look through it.

That said I will now proceed. What happened after my mother left Haslar that is what I keep on asking myself. Many questions but no answers. So what do we see, a person albeit elderly, my mother at Haslar having against the odds come through for her age anyway, a serious operation. I am told they (Haslar nursing staff and doctors) are amazed that she has done so well.

Let us be honest about this shall we. My mother just prior (Monday 9th Nov) was and had been for a number of days previous to this able to sit in a chair and also be wheeled around Haslar to for example the out-patients for tea and the NAAFI shop. She could feed herself with the use of a spoon, eat a sandwich unaided and hold her own cup to drink from. Talk relatively coherent to the point of 'moaning' at me when I went for a cigarette, saying that she knew I would not be back for ages. Something she never said at the War memorial (W.M. from now on).

Now let us move onto the W.M. and the difference in her well being between Mon 9th Nov and Fri 13th Nov (certainly an unlucky day for her). We now see an elderly lady sedated to such a level that she is just about helpless. She was supposedly in pain bed sores on her heels I was told. I reply that at Haslar they were far worse at one stage and the only painkillers given the week previous (check the records shall we) were taken orally IF that is when asked my mother requested some. So the pathetic excuse given by the W.M nursing staff holds no water. Two days my mother was in this state and on the third (Sun 15th Nov) she was still feeling the effects of them. Morphine based I believe weren't they.

We are moving on again so stay with it please. On Mon 16th Nov there was or appeared to be an improvement in that my mother's eyes no longer had that glazed look about them. She also ate a whole sandwich (Tuna mayonnaise) less some of the crust and a medium sized banana, both of which we brought into to her. BUT on Tues 17th Nov she was back to square one as she was on Fri 13th Nov. Not so far as I am aware of because of any kind of sedative having been given to her but she was and this could well be the cause of the sudden deterioration in her condition, dehydrating. I had along with others(registered care assistants from Addenbrooke) observed on the three days prior to this that she was passing very little urine. What cannot speak likewise cannot lie for the bag into which the catheter deposited the urine had hardly anything in it. Of course it could have been emptied earlier but I doubt it. Why do I, read on.

When I complained about my mother's obvious dehydrated state. I must admit I lost my temper in frustration and who wouldn't have on being told when I asked why they had not attached a drip to my mother that she, a rather buxom blonde haired staff nurse, was not at liberty to say why my mother was not on a drip and added to this that they were not available in Dryad ward. You don't believe me, then that's OK by me because my mother's visitors heard what your staff nurse had said to me.

Fair play to the staff nurse though because she was no doubt only following orders the same as I had to in the R.A.F. As they say the buck has to stop somewhere and that is what I am trying to do, find out exactly where it stops.

You already know what followed. More heated words were sadly exchanged and security was called. Supposedly on the pretext that someone or other was worried in case I hit them. I had already made it known that I [redacted]

[redacted]

Press on shall we because in due course about half an hour after the little altercation a doctor arrived and spoke to me about my mother, what else but [redacted] that I was impressed by what she had to say. The top and bottom of it is a drip at this doctor's instigation was attached to my mother and that is all I had asked for in the first place. Better than that the next day (Wed 18th Nov) you personally from all accounts saw to it that a drip and liquidized food was administered to my mother. I thank you for doing that. Too late though, but at least your actions exonerated why I let forth with such a verbal outburst and in light of what happened after it, then I am glad that I did.

My mother is a fighter, it serves not one iota what she said under yourcare BUT I was informed that she did say, to quote her exact words 'I will survive' Poignant wasn't it. Now look at what has happened. I feel and I am not alone in this that had my mother received the care that should have been afforded to her from day one at the W.M then she would have had a good chance, in spite of any detrimental prognosis, to survive as she put it. BUT what occurred on the Fri 13th Nov through and including Tues 17th Nov killed off (excuse the term) any chance she might of had. Of course we all know that she is an old lady and time was limited anyway, isn't it the same with us all and even more so when one reaches my mother's age seemingly healthy or otherwise. We cannot live forever can we.

Life though is precious and all stops should be pulled out regardless of age unless perhaps someone has advanced terminal cancer. It then becomes a happy release to die. Think about this will you because if this short journey called life is all that fate has chosen to allow us then shouldn't we enjoy it as long as possible. Of course we should. My mother wasn't so lucky was she. Just take how since Sunday 22nd Nov she has hung onto that last thin thread of life. Makes you wonder doesn't it IF as I have already said she had been given that chance no matter how slim from Fri 13th Nov. We will never know because she was deprived of that chance.

I expect you have become bored with this, lot to read isn't it, then again you might not have reached this far. Hope you have though. If so then stick with it awhile longer. I am not going to go away that easily, believe me. What is it they say about watching this space. I had already heard rumblings of discontent, before my mother was admitted to the W.M., from others whose loved ones had been cared for at the W.M. (I use the word care loosely). Since then on prying further, a word here and another there I have heard quite a lot. Oddly enough as I was having a cigarette outside the Ann's Hill entrance I casually remarked to a couple enjoying a smoke that if they wanted their relative to survive then get them out of here. 'You don't have to tell us about it we know' was their reply. I am digressing aren't I so let us return to those rumblings I was on about.

Anyway on digging deeper it now appears that a trickle of a stream has become a steady flowing one and in time it could turn into a torrent, similar to what they call a flash flood. Who knows I don't and neither do you. Please though do not consider this an attack on you personally because it is not. A misapprehension it would certainly be and if during the reading of this letter you thought it was then let me set the record straight here and now because it wasn't. The W.M is probably no different to many hospital spread across the country.

We are nearly there but I wonder how many in the past have felt that their hands were tied and short of what I tried to do for my mother's sake, they could do nothing to help their loved ones. You are thinking perhaps that I am about to go on some sort of personal crusade or other. Not really because it is too late for my mother and yet I might be able to achieve something for those who follow in my mother's footsteps.

If you feel that in any way my letter could be thought of as libellous then fine sue me. My solicitor (not the one I spoke to in Gosport) said that not only is it the least costly of ways to get the W.M. to court, but it is the easiest. Then everything that has happened to my mother and no doubt there are others in the same position or have been will become common knowledge. The power of the press is limitless and can probe deeply and damagingly aswell so I have been told. Perhaps though I should change tack and steer towards them in the hopes of being welcomed into their harbour whence to launch my campaign.

Finally, did I hear a sigh of relief, I wish to say one thing concerning myself. Haslar were honest with me in that they said my mother might well die during the operation and that I should be prepared for this to happen. At every stage at what I thought would result in my mother's recovery I was kept informed of her progress. Now compare their approach with that of the W.M. No one bothered to speak to me about my mother until I caused a ruckus. Anything I said or asked prior to this was brushed aside and good example is when I mentioned how long would it be before they got my mother out of bed. When I remarked that Haslar had done so in three days I was rebuffed with a curt reply along the lines of Haslar do things differently. Too right they do thankfully and to all accounts according to the book which from what I have read or heard when it comes to hip operation and especially with the elderly because of the possibility of pneumonia setting in, that patients should be up and out of bed a.s.a.p. Seems this pertains to my mother doesn't it. So Haslar are just doing what should be done in every hospital. Not in the W.M. it wasn't.

In closing I will reiterate that had my mother received the care she should have I firmly believe she would have made it. Why do I say this because for the past four days up to the 27th Nov (today as I write this letter) she has been in what could best be described as a coma, unaware as she is of anything. To all intents and purposes she is on shall we say, automatic pilot in that her body refuses to give in even though all else has failed. Which brings me back again to the fact that she was a lot stronger than any prognosis of yours, meaning of course the doctor's. In other words from the moment my mother entered Dryad ward she should have been given a chance and that is all I wanted for her in the first place.

From what I have seen and along with others (five employees from the Addenbrooke residential home) when compared to Haslar then basics were sorely missing at the W.M. and probably have been for quite awhile.

That's it a life comes to an end but if you unfortunately ever find yourself in circumstances similar or the same as mine, which incidentally I hope you never are, then cast your mind back will you to today and all that I have said. Without doing so intentionally you probably will.

Yours **Code A**

(Mrs.E.I.Purnell's son)

(1) CHRONOLOGICAL LIST OF EVENTS DAY BY DAY FROM THE TIME MY MOTHER BROKE HER HIP UP TO JUST BEFORE SHE DIED.

Sunday 25th Oct.

My mother fell and broke her hip in Addenbrooke residential home. Went to Haslar hospital. I was told that IF they operated and IF she had a massive heart during it they would not in her best interests 'pull out all the stops' to revive her. I agreed with this. A decision was made later to operate, because they considered her heart was strong enough to come through it. It was carried out on the Monday. Epidural.

Monday 26th Oct.

Operation a success. I saw my mother and departed Haslar about 8pm. Only home an hour or so before a phone call was received. Her condition had deteriorated and it was suggested that I return to the hospital. Blood pressure very low and on arrival I noticed it was 74/50. I stayed there all night.

Tuesday 27th Oct.

Mother much to everyones surprise had improved considerable and was now out of danger.

Wednesday 28th Oct.

Mother in bed all day, but eating fairly well. I fed the evening meal to her that evening and on the following days apart from Wed 4th Nov & Sun 8th Nov assisted her with the evening meal.

Thursday 29th Oct.

Mother out of bed and sitting in a chair on an air cushion. Bed sores on heels developing. Not able to fed herself at this stage with any degree of dexterity in that she could only use a spoon or eat a sandwich unaided. She could though hold a cup to drink from, but not fill the glass (from a jug) because her hands shook quite a lot. Have done for sometime.

Friday 30th Oct.

Haslar doctor's amazed at her progress when considering her age. Now using a fork, but meat had to be cut into small pieces for her. Still sitting out of bed. Much brighter and talking a lot better.

Sat.31st Oct through to and including Mon.2nd Nov.

More or less the same as from Wednesday 28th Oct.

Tuesday 3rd Nov.

Mother was now at the stage where she could be pushed around the hospital in a wheelchair. Took her to the outpatients for tea&biscuits. Visited the NAAFI shop where she choose something (crisps, milk chocolate buttons and a cheese dip complete with finger sized biscuits) to eat between meals.

Wed.4th Nov through to and including Fri 6th Nov.

Much of the same again, but very bright eyed and bushy tailed so to speak. If asked whether or not she wanted a painkiller (given orally) she would reply mostly in the negative as she had done on prior days to this one. Compare this with what happened on Fri 13th Nov at the War Memorial Hospital.

Saturday 7th Nov.

A Dr.Lord from the W.H. came to see my mother. Note the date because she never saw her again until the evening of the 23rd Nov. In her opinion my mother was ready to be transferred to the W.H. No day fixed but sometime the following week.

Sunday 8th Nov.

Mother about the same as the previous week.

Monday 9th Nov.

I was told by Haslar that my mother would be going to the W.H. the following day.

Tuesday 10th Nov.

Lack of transport my mother would now be on her way to the W.H. on Wednesday the 11th Nov.

Wednesday 11th Nov.

Mother now in the W.H. Dryad ward. I visited my mother that evening and she appeared rather tired. Not one of the nursing staff or anybody for that matter asked whether or not I was a relative or her son perhaps. The general attitude was that of not being bothered as though it was too much effort. Considering that the doctor I spoke to on the 17th Nov said that my mother's prognosis was poor then

surely I should have been told this at the outset. NOT A WEEK LATER. To have your hopes dashed at this juncture after having seen such good progress at Haslar was quite a blow I can tell you.

Note that if I had not complained so vehemently about my mother's deteriorating condition on Tuesday 17th Nov. (see below what happened on this day) I would not have been spoken to by any doctor at the W.M. and surely as a matter of routine I should have been after my mother was admitted to the hospital. It was only because of my actions on Tuesday 17th Nov. that one saw fit to speak to me.

Thursday 12th Nov.

Mother much improved. Good colour, eyes bright. I fed her the evening meal just half a sandwich and one medium sized banana (I brought this in) and the whole portion of a milk based pudding. I was pleased that she seemed so much better.

Friday 13th Nov.

I arrived about 3pm. My mother was or appeared to be very poorly Could not believe the difference from how she was at Haslar. It can happen I was told due according to this staff nurse to being transferred from one hospital to another. Elderly patients in particular can suffer a relapse she added to which I replied then why move them until they are fit enough to travel. No reply forthcoming. Struggle to feed my mother the evening meal and then it dawn on me. Her condition had nothing to do with what that staff nurse had said because it was patently obvious that my mother had been sedated such was her trance like state. Not purposely perhaps but more in an error of judgement in that it was supposedly given to ease her pain. Morphine based so I believe from what I was told. At the time I accepted their explanation. Somewhat naively I might add.

Saturday 14th Nov.

Mother just the same and I realised (as did others - see footnote page three) that she was infact still under sedation, for the pain of course! I complained about this and wanted to know why. A nursing sister took me into a side room along with another nurse of lesser rank and my ex-wife. I was told that my mother needed painkillers (singular or plural is irrelevant) for the bed sores on her heels. I stressed that they were far worse in Haslar and that my mother had only been given a painkiller if on being asked she wanted one and then only orally. Not to the strength either of those given to her at the W.M. In no uncertain terms I was told that the W.M. knew better than Haslar. On that I beg to differ. I replied quite hostile in tone that such a deterioration in my mother condition was not possible from the time she left Haslar and being pushed around in a wheelchair to the semi-conscious state she was now in. The sister actually asked about my mother losing the will to live, to which I retorted that her mind, due to increasing dementia was not capable of thinking that way.

Sunday 15th Nov.

Mother in my opinion and others i.e. qualified care assistants, was now coming out of sedation. A nurse came into the room at aproximately 4.30pm took a blue file (my mother's records or whatever) with her and returned about fifteen minutes later and remark rather sarcastically 'No drugs today'. There are bona fide witnesses to everything I have said from Wed 11th Nov. up to and including Tues 17th. Nov. I will reiterate. It wasn't so much sarcastically, but coldly.

Monday 16th Nov.

Mother much brigther, ate well. I asked about her getting out of bed to which they replied, her bed sores (heels) needed to heal first. I thought here we go back to the same excuse for everthing, those bed sores. Yet Haslar had my mother out of bed in three days. NOTE my mother is still in bed and has been since the day of her arrival at the W.M. 11th Nov. As of writing this the Saturday 28th Nov nothing has changed. Too late anyway now.

Tuesday 17th Nov.

The day I believe my mother began to die for she was in a very poor state. I noticed as I had done on the previous three days that she was passing very little urine into a bag. Catheter tube attached. When a registered care assistant from Addenbrookes arrived, some twenty minutes prior to myself, she realised that my

mother was dehydrating. She said as much to the duty staff nurse best describe as I do not know her name and sorry about this, a rather buxom blonde haired lady. Anyway further to this she asked the staff nurse why the room was in darkness to which she replied my mother requested that the lights be turned out. YET everyone at Addenbrookes residential home will verify that my mother always wanted every light on in her room, even the one over the wash basin. I then stepped in and asked the same staff nurse about putting a drip on my mother and she replied that there wasn't one on the Dryad ward. I continued by saying why wasn't my mother on one anyway and was told by the staff nurse that she was not at liberty to say. What does that mean because it was certainly a strange thing to say. I admit by now I was raising my voice, shouting if you prefer and the staff nurse said that I was upsetting other patients. My mother though is in a room of her own. Following this she summoned security to remove me from the ward. I left on my own accord, but she said to my friends and the care assistant from Addenbrooke that I would not be readmitted to the ward. In due course and at my earlier request a doctor saw my mother and put her on a drip. A tete a tete ensued between doctor, staff nurse and a junior nurse on the one side and my ex-wife, a family friend and myself on the other. I asked the doctor what the odds were of surviving an unmonitored aneurism in the ascending aorta and she replied very slim. [redacted] I mentioned this solely because of one of the Dryad nursing staff, I think I know who, told the security officer that she thought I was going to hit [redacted] and that is why she had called security. [redacted]. Anyway I am digressing but it is a point to remember if the subject of a security officer raises its head again. I was also told by the doctor that my mother's prognosis was not good but denying her a drip when she was dehydrating certainly did not help. As for any prognosis please read what I have about them. Footnote page four. In a word on this day my mother was intentially or otherwise being deprived of basics to sustain life.

Wednesday 18th Nov.

Having stated the previous day that I was about to take a different course of action, implying seeing a solicitor with the view of suing, a near impossible thing to do, for negligence in that my mother was being deprived of the basics and stating emphatically that unless I could see an improvement in my mother to the degree that she was at least out of bed and responding to treatment in preparation to returning to a nursing home I would not return. Failure to do so would result in the hospital having, in the event of her death, to arrange for the cremation of my mother. Drastic measures I know, but to some extent it worked so exonerating me from my verbal outburst on the 17th Nov, because on the morning of the 18th Nov a director of the W.H. - a Dr. Reid from all accounts - did see my mother and since then a drip and liquidized food has been administered to her. I am sure though that what had happened to my mother on the 13th Nov the Friday through to and including the 17th Nov the Tuesday has resulted in their efforts on and since the 18th Nov being of no avail.

Sunday 22nd Nov.

Mother steadily getting worse. At first on the Thursday previous she was eating relatively well, Friday much of the same but since then she appears to be rejected food by mouth to the extent of spitting it out.

Tuesday 24th Nov.

Mother now in the state of or similar to a coma. No reaction when spoken to, eyes glazed and completely unaware of what is going on around her.

Saturday 28th Nov.

Appears to be near to death, but unbeknown to her the body is still fighting against it.

Footnote as mentioned on page two Saturday 14th Nov. Five care assistants from Addenbrooke residential home have seen my mother either at Haslar or the War Memorial. Three of which have seen her at both and spoke to nursing staff at the W.H. about the difference in my mother from when she first left Haslar. One was present at the altercation on Tuesday 17th Nov and witnessed ruckus that went on at the W.H. that evening between myself and a member of the nursing staff. All are willing to make statements on my behalf and more importantly my mother's, not that it will

help her now, but it could help others, especially the elderly vulnerable as they are, who should happen to follow in my mother's footsteps.
Footnote as mentioned on page three Tuesday 17th Nov second to last line.
Prognosis is a very ambiguous word in that doctors or whatever can see things differently. Granted it is difficult as in my mother's case because they are elderly and a pattern does tend to be there. And yet each persons, no matter the age, resilience as to ails them may not manifest itself until a later stage thereby not being present at the initial prognosis. What though does this word mean anyway. A forecast especially as in a disease, but since when has a hip operation been a disease. It could be that I am splitting hairs, but you surely must get my gist.
Let me give you a good example of what I mean about the word prognosis and although it may seem out of place with regards to what I have been saying it is the best one to explain the point I want to make and if nothing else it will give you or anyone else for that matter some food for thought.
Football pools it is just an analogy that is all but hear me out. I know you are probably thinking what is he on about now. Well as it so happens some years ago for a whole season I made notes purely out of curiosity on games postponed due to inclement weather. You see football pool companies use a panel of so called knowledgeable people about the game of football of course to give the result of any void games. So in effect they predict what they think the result might be and whatever they decide upon stands in relationship to the gambling element of football pools. Now I wanted to see just how accurate these predictions were when comparing them to the actual results when the games were played at a later date. It did not come as any surprise that they wrong in their predictions over fifty percent of the time. Do you see what I am getting at, of course you do when applying this to a doctor(s) prognosis.
Rubbish do I hear the two things are completely different. Are they though because both are only making predictions, that is all they can do in the circumstances. So the football pool analogy might well apply to any doctor when making his or her prognosis in that their prediction is wrong when applied to the patient they had made them for.
I firmly believe that is what happened in my mother's case and if not then how come she is still 'hanging in there', albeit in a state of unconsciousness. I will not waste your time repeating why I think she is in this state. You could say though hypothetically naturally that a panel of some sort, similar in a way to the football one, had decided not to wait and see but instead forecast the final result beforehand. Then they were as so often the football panel was completely wrong and similar to a football team my mother's fate was sealed before the game was ever played.
Sadly this was not a game, I wish it were and here we (populace at large) are believing fervently that our hospitals were there to help patients to live. If this is deemed to be true and I sincerely pray it is, then give those patients that one last chance, no matter the odds against them, to live.
Perhaps instead of following a set policy it would serve the patients interests far better if they were treated as individual cases, each different from the other because from I have seen and heard I do not think they really are, definitely not if they are elderly I don't.

LETTER TO MAX MILLETT.

2

REPLY TO HEALTH CARE TRUST

LETTER 9-1-99

Code A

11-1-99

Dear Sir,

I received your letter on Saturday and having read it many times I am giving you the benefit of the doubt that you have not received/read a copy of the chronological list of dates that I have enclosed, because if you had then there is no way you could have come up with the report that you have.

Pain Relief.

As stated in my list on for the Friday 13th Nov and the Saturday 14th Nov whilst my mother was a patient at Haslar she was quite capable of saying to the nursing staff whether or not she felt the need for a pain killer (orally). As for Dr.Lord she never saw my mother from the 5th Nov until the 23rd Nov and that to me speaks volumes in itself.

Hydration.

Read again if you will please what happened on Tues.17th Nov. It wasn't the nursing staff on duty that day in Dryad ward that noticed my mother was dehydrating was it. See my list. Now how do you or they explain that away. The only reason anything was done to be blunt about it was because of the stink up I caused. Unbeknown to you or anyone else I have photographs taken of my mother in the War Memorial and next to her daily newspapers prominently showing respective dates and including amongst them Tues.17 and Wed.18th. Do I need to say more. Perhaps they will be useful in court at some later date.

Mobility.

In Haslar my mother was out of bed and being wheeled around the hospital and yet the War Memorial considered this a backward step. Waht nonsense.

Anyway I intend to pursue my complaint to the very limits, most likely sueing the hospital for lack of care. I have some good qualified people in nursing car who are willing to attend court. I firmly believe that lack of basic care unintentially or otherwise whilst a patient at the War Memorial contributed to my mothers death. The cause of which has been stated as broncho pneumonia. That might well have been what finally killed her, but it certainly was not the primary cause. I've already said what I think that was.

Take a look at what my mother's solicitor said regarding the War Memorial having had discussions with me regarding being happy about allowing the solicitor to proceed with funeral arrangements. They were no discussions. So how do you explain them saying such a thing.

You letter is biased in the extreme in that you have gone to great lengths on the War Memorials behalf. As for my side of it well I did receive a cursory letter that you were looking into things.

In closing as I said in the outset in my letter to Dr.Reid that I will not go away easily. Not until I'm am truly satisfied and as things stand now I am far from that.

Yours faithfully,

Code A

M.E. Wilson (mr)

P.S. You mention my not speaking to Dr.Lord on 23rd Nov. Through my ex-wife Dr.Lord was asked if she wouldn't mind speaking to me elsewhere because of what happened in the Dryad ward on the day 17th Nov that the duty staff nurse called security to have me removed from the ward. This nurse thought I was or might be likely to hit her. [redacted] flippant she could have floored me with one blow. I only weight 10½ stone and she was I should think around the fifteen stone mark. No contest.

PORTSMOUTH
HealthCare
NHS
TRUST

Mr M E Wilson

Code A

Our ref
MM/BM/YJM/wils9jan
Your ref

Date

Ext
Code A

Dear Mr. Wilson,

I am writing further to my letters of 7th and 24th December, 1998 now that reports have been received from the staff involved in your late mother's care at Gosport War Memorial Hospital.

First I should like to reiterate how sorry I am that your sadness at this time has been compounded by your concerns about the care your mother received whilst a patient on Dryad Ward. I appreciate that you believe the downturn in her health which occurred during this period resulted from both the nursing and medical management of her care. In particular you identify three specific areas - pain relief, hydration, and mobilisation - each of which I will address separately.

Pain relief

When Dr. Lord saw Mrs. Purnell and yourself at Haslar Hospital on 5th November, 1998 your mother already had pressure sores on both heels and on her right elbow. She was observed to be in pain on admission to Gosport War Memorial Hospital and was written up for co-codamol and oramorph. When you saw Sister Hamblin on 14th November, 1998 she was able to explain the need for those drugs to you. In addition on 15th November, 1998 Mrs. Purnell had problems with neck and back muscle spasms and was seen by the duty general practitioner who prescribed diazepam. Your request for all analgesia to be ceased was discussed with Dr. Brooke on 17th November, 1998 but she did not agree with your view. Again, the need for these drugs was explained to you by Senior Staff Nurse Hallman, and the staff continued to provide what they believed to be the best possible care, whilst acknowledging your own views were different to theirs. Dr. Brooke requested a second opinion and Dr. I. Reid, Medical Code A, saw your mother on the evening of 17th November, 1998 and the morning of the following day. When Dr. Lord saw your mother again on *
23rd November, 1998 she was in great distress and Dr. Lord gave instructions for diamorphine to be administered subcutaneously if required.

/continued - page 2

* DR LORD DID NOT SEE Code A UNTIL 23RD NOV (MON) PREVIOUS TO THIS SHE SAW HER ON 5TH NOV. AT HASLAR QUITE A TIME GAP 18 DAYS IN VIEW OF Code A'S DETERIORATING CONDITION.

PORTSMOUTH HEALTHCARE NHS TRUST CENTRAL OFFICE

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

* I ASKED TO SPEAK TO DR LORD SOMEWHERE OTHER THAN DRYAD WARD BUT SHE REFUSED TO

Dr. Lord and Mrs. B. Robinson, the Hospital Manager, were* expecting you on the afternoon of the 23rd November, 1998. However, you did not come to the ward and, therefore, there was no opportunity on that occasion to discuss your mother's condition and your concerns.

Hydration

Mrs. Purnell had difficulty in swallowing and her nutrition was variable even in the immediate post-operative period in Haslar Hospital. When she was first admitted to Dryad Ward Mrs. Purnell was* able to drink fluids freely when she wished. However, her condition did deteriorate and she developed generalised oedema which Dr. Lord felt was due to a low protein level. When her swallow deteriorated it was a difficult decision as to how she could be best hydrated. Subcutaneous fluids were considered the best option as it was important not to overload her system with fluids Even after these were started there were some days when Mrs. Purnell could have small quantities of pureed diet and thickened liquids and these were given to her.

* NOT IN A POSITION TO DO SO DUE TO BEING SEDATED FROM MORGA SHE WAS ADMITTED TO WARD

* AT LEAST HASLAR GOT MY MOTHER OUT OF BED. AS FOR BEING ASSESSED BY THE W.M. THAT SHE SHOULD BE KEPT IN BED SURELY A BACKWARD STEP IN LIGHT OF HASLARS EFFORTS.

Mobility

When Dr. Lord saw you with your mother at Haslar Hospital on 5th November, 1998 she warned you that the combination of her long-standing dementia and the pressure sores on both heels would make mobilisation difficult. You were advised to cancel her place at Addenbrooks, which you had, in fact, already done.* Mrs. Purnell had oedema in both legs and on admission the nursing staff assessed her to be in need of being nursed in bed on a pressure relieving mattress. This was to relieve the pressure and ease turning to relieve other pressure areas, and to keep her legs elevated to aid reduction of the leg swelling. This was explained to you by nursing staff on 14th, 16th and 17th November, 1998. The staff were clear that you did not accept their view but had to be guided by their professional assessment of the best care approach for your mother's needs.

In general your complaint reflected a great deal of concern about issues on which there were fundamental disagreements between yourself and the professional staff caring for your mother.

* Such situations are extremely difficult for all concerned, but there do not appear to be any obvious ways in which the management of the situation could have been improved. You were effective in making your views known, and on the whole the staff made extensive efforts to communicate with you - although this was not always successful, and apologies are proffered to you for that.

The staff are convinced that the care your mother received was entirely appropriate. Although she was transferred to Gosport War Memorial Hospital for gentle rehabilitation sadly she did deteriorate quite quickly in the end. It would now appear that the staff felt you were more aware of the seriousness of the situation than appears to have been the case. For this fundamental misunderstanding we can only apologise as, although it would not have affected the outcome, it would probably have influenced your views on what happened

/continued - page 3

* SEE LETTER FROM N.H.T. DATED 8.2.99 AFTER MEETING BETWEEN THEM AND MYSELF.

I have tried to answer your questions and your main complaints; however, please do not hesitate to contact me if there is any further action you would like me to take.

Yours sincerely,

Code A

Max Millett
Chief Executive

PORTSMOUTH
HealthCare
NHS
TRUST

Our ref
WMH/LD
Your ref

Date
08 February 1999
Ext
Code A

Mr M E Wilson
Code A

Dear Mr Wilson

Thank you for attending the meeting on 3rd February 1999 to discuss the issues raised in your letter of 12th January 1999 to the Code A under our complaints procedure.

Present at the meeting were Code A Code A Community Health Council representatives.

Using the main headings of Mr Millett's reply to you, I append a summary of our responses to your concerns.

Pain Relief

Code A explained that the medical and nursing staff had assessed that your mother was in pain and pain killers were prescribed as necessary.

He further assured you that only very low doses were given and that these were only given when necessary, as part of a pain control programme.

Hydration

Code A went on to explain that as your mother's condition deteriorated, her ability to take fluids, fluctuated. However, fluids were given whenever she was able to take them orally.

We agreed that your mother had taken minimal fluids over the weekend of 14th/15th November 1998.

Code A stated that he felt, given your mother's general frailty and her dementia, it was reasonable not to rush into giving subcutaneous fluids.

FAREHAM AND GOSPORT DIVISIONAL OFFICE

St Christopher's Hospital
Wickham Road, Fareham, Hants PO16 7JD
Tel: 01329 822269 Fax: 01329 822094

We noted your concerns about this.

Your dissatisfaction on 17th November 1998 and the confrontation with medical and nursing staff regarding fluid requirements for your mother, culminated in the commencement of subcutaneous fluids.

We noted your concerns regarding this point.

Mobility

The issues you raised regarding your mother's mobility, after transfer to Gosport War Memorial Hospital were explained as being the best way to treat her pressure sores, swollen legs and pain level on admission.

There was never any intention of keeping her in bed, if her condition had allowed her greater mobility.

Communication

The issues you raised in regard to staff introducing themselves to you, explaining your Code A's condition and not finding out who you were when you visited, were not acceptable to us.

A full apology was given to you on these issues by Mrs Robinson.

Summary

The meeting concluded with you not accepting our explanation of all the points discussed and that you would await my letter before deciding with the Community Health Council if further action would be taken.

You wanted to make sure that the issues you raised on behalf of your mother's treatment were not repeated to other patients in future.

I have consulted with Dr Reid and Mrs Robinson about the points raised and an action plan of issues will be discussed with all the ward staff and medical staff on Dryad Ward at Gosport War Memorial Hospital.

/continued ...

See Page 2 NHT letter 9-1-96
They could see no obvious way of improving the situation'
BUT NOW THEY HAVE.

These will involve the following areas:-

* Admission Protocols ~ to include relative support review
* Pain control
* Review of fluid protocols
* Medical cover requirements over weekends/Bank Holidays

(You may also be interested to note that from the week commencing 16th February 1999, there will be a weekly (instead of fortnightly) ward round by a consultant).

I hope you will find that we have taken your complaint seriously and will instigate changes as appropriate that will help overcome further such concerns being raised by other patients/carers in the future.

Please accept my apologies for all the stress and pressure this has incurred whilst you [redacted]

Copies of this letter will be sent to the Community Health Council.

Yours sincerely

Code A

Fareham & Gosport Division

Copies to:

Code A

1 2 THIS CONCERNS FIRST MEETING HELD. 3.2.99

Questions and points raised at the meeting held on the 3-2-99. Most of which pertain from what I disagree with in the N.H.C. Trust letter of the 9-1-99

First mention Bronchial Pneumonia. An infection causing fever. rapid shallow breathing. Often terminal in people who are seriously ill. Since when has a broken hip been an illness. During 10 days my mother was in a coma prior to her dying, pulse was normal. no difficulty in breathing. no fever. If she had B.P. then antibiotices should be administered. B.P. might well have killed my mother but the aotual cause leading to B.P. was the obvious lack of car given to her in the War Memorial Hospital.

What I would like answers to - referring to the letter from Max Millett of the N.H.C.Trust - is what the War Memorial Hospital told him.
Under the heading of Pain Relief. For a start Dr.Lord did not see my mother after the 5thNov98(Thursday) until the 23rdNov98(Monday). Now unless she was elsewhere, on holiday or something similar then this is quite a time between her seeing my mother. On the 23rdNov98 Dr.Lord gave instructions for diamorphine to be administered to my mother who was in great distress. How come there is no entry of this having been given to my mother on her medical record. If my mother was receiving diamorphine I would've expected the amount given and frequency of to have been written down. As for discussing my mother's condition as stated on page 2 line 3 a bit late in the day so to speak wasn't it. Surely I should have been made aware of her condition at the outset of her being admitted to the War Memorial and not some 12 days later. Sister HAMBLIN spoke to me on the 14th Nov98(Saturday) only after I insisted on speaking to someone with an amount of authority. I told this lady that I wanted it to be known that I was totally against my mother being given morphine and that I was willing to take the responsibility for her not being given painkillers other than co-codamol. I further said that I could see no reason for my mother being sedated as she was, which leads into why what it says under Hydration is in the most part a lie. No dates you will notice are given in this section but as they say when my mother was first admitted to Dryad Ward she was able to drink freely, as she wished. Not so because on day two the 12thNov98 my mother was already being given a high dosage of morphine and was incapable because of it to drink fluids as she wished. As for her condition deteriorating then too much morphine can cause pulmonary complications and lead to oedema. No satisfactory answer either as to why my mother was found to be dehydrating on the 17thNov98 by an outside party who happened to be visiting her. This was around 3.45pm. Subcutaneous fluids were given to my mother on 18thNov98 (possibly the evening before) but whether or not they would have been if I had caused such a rumpous on the afternoon of the 17thNov98 is another question. See 'chronological list of events' of which all parties have a copy.
Now to the final heading of Mobility. Not a lot can said other than the comparison of approaches to the recovery of patients having undergone a hip operation.

What do I mean by that. Well according to everything I have heard or read about caring for patients after a hip operations seems to be along the lines of what Haslar Hospital do, which is get them out of bed as soon as it is practically possible with mobility being the key word here. Not so if I am to believe what I was told at the War Memorial because they viewed Haslar's approach as a backward step and that patients should be kept in bed to relieve any sores they might have. In my mother's case the bandages were already off before she was transferred to the War Memorial. They mention in this paragraph about my mother being on a pressure relieving mattress as though they were doing something special. My mother was on one in Haslar, but from the way the W.M. was talking you would've thought that Haslar did not have such things.

A final footnote of what came out of the meeting on the 3-2-99 with regards to the War Memorial and the statement made by the N.H.C.Trust in their letter of the 9-1-99 in which they atate that there did not appear to be any obvious ways in which the management of the situation could have been improved. Why then in their letter to me after the meeting did they admit improvements could have been made and further to this were being made.

PORTSMOUTH
HealthCare
NHS
TRUST

Mr. M. Wilson,

Code A

Our ref
MM/BM/YJM
Your ref

Date
24th June, 1999
Ext
Code A

Dear Mr. Wilson,

I am responding to your letters of 12th June, 1999 (received in this office on 15th June, 1999) and that of the same date addressed to Code A. I am very sorry to hear that you remain dissatisfied despite our several attempts to resolve your complaints. In particular it is a matter of regret that issues still remain after the formal meeting between yourself, Code A Code A and Mrs. Barbara Robinson (from the Trust) and Code A and Code A (from the Community Health Council). All the staff concerned with Code A Code A's care are genuinely sorry that your grief has been compounded in this way, and hope you will find the following helps in finally resolving your concerns.

* NOT GRIEF. FINGER IS THE WORD AT THE LACK OF CARE THAT I BELIEVE CONTRIBUTED TO MY MOTHER'S DEMISE.

Your letters identify the key outstanding issues as:

(a) The need for morphine to have been prescribed.
(b) The decision to treat - or not.
(c) Your knowledge of other similar complaints
(d) Complaints about your own treatment, and the stress you have experienced.
(e) Your mother's experience in a darkened room on Dryad Ward.
(f) Dehydration.

Code A and the Gosport War Memorial Hospital staff have been given an opportunity to comment on both letters, and the following response reflects their views:

(a) *The need for morphine in response to the pain resulting from the bedsores*: Bedsores themselves can be extremely painful, and the degree of pain does not necessarily equate to the size or degree of the problem.* However, your mother was not simply given morphine for her bedsores.

BANDAGES TAKEN ON 14TH NOV. 98 BEDSORES WORSE AT HASLAR BUT NO MORPHINE WAS GIVEN TO HER

* SO WHAT WAS SHE GIVEN MORPHINE FOR ON 12TH NOV. 98 THROUGH TO AND INCLUDING 16TH NOV 98.

PORTSMOUTH HEALTHCARE NHS TRUST CENTRAL OFFICE

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

SO AT HASLAR ON THE 10TH NOV 98 SHE WAS NOT IN PAIN THERE FORE NOT IN NEED OF ANY KIND OF PAINKILLERS . TAKEN ON 12TH AT THE W.M. HOSPITAL SHE NEEDED 20mg OF MORPHINE WHY? FOR PAIN

* Both the medical and nursing staff assessments at Gosport War Memorial Hospital concluded that Mrs. Purnell was suffering a significant level of pain, and she was given a low dose of morphine to relieve generalised pain and discomfort.

The fact that she was given no pain relief at Haslar from 5th November, 1998 until her transfer to the War Memorial Hospital does not, as you believe, prove that the subsequent use of morphine was inappropriate. As you would expect, her condition was changing from day to day and the move itself may have contributed to her discomfort. The staff could only react to her condition and needs as they found them not as they had been, and this is what they did.

(b) *The decision to treat*: You express the view that "someone of authority" decides in each individual patient's case whether or not the cost or effort of treating them is justified - we would be appalled if this were the case. It is not a resource issue, it is a matter of clinical judgement as to what is best for the patient. There has to be an assessment of each individual's potential to survive and an acceptance that in some instances intensive active treatment may simply prolong the pain and distress by delaying the inevitable outcome.

WHY THEN WAS SHE TRANSFERRED FROM HASLAR HOSPITAL

When Mrs. Purnell arrived at Gosport War Memorial Hospital she was suffering from many health problems, and was in significant pain. She was close to the natural end of her life, and it is, I think, regrettable that this was not made clearer to you at the time. I have already highlighted this, and apologised to you, in my letter of 8th January, 1999. XX WHY THEN STATE THAT MY MOTHER WAS GOING TO THE WMH FOR GENTLE REHABILITATION WITH THE VIEW OF GOING FROM NG26 TO A NURSING HOME. } See Page 4 Section 10 OMBUDSMANS REPORT.

(c) *Other complainants*: I am sorry to hear that other patients or relatives have expressed their concerns to you - and can only advise you to encourage them to complain directly to me, so that their individual circumstances can be investigated. Our complaints leaflet is widely available and I hope it is clear that we do want to hear from people who have reason to complain, so that any problems identified in this way can be addressed.

(d) *Your own complaints*: You again indicate that compensation and legal redress are on your agenda, and I can only reiterate that the complaints procedure is not appropriate in such circumstance and that you should instead pursue matters through the formal legal channels.

(e) * *Left alone in a darkened room on Dryad Ward*: The time in question was a winter afternoon, with the evening drawing in. Mrs. Purnell was asked if she would like the main light switched on and she declined. We appreciate that you do not think your mother would make such a choice, but this is what happened.

*

12 Nov. 98	20 mg.
13 —" —	10 mg
14 —" —	10 mg
15 —" —	20 mg.
16 —" —	10 mg

TOTAL 70 mg morphine.

* THE STATE MY MOTHER WAS IN DUE TO AMOUNT OF MORPHI GIVEN TO HER UP TO THE 17TH NOV 98 WAS SUCH THAT NO WAY COULD SHE HAS ANSWERED ANY QUESTIONS COHERENTLY. ASSUME TIME AS 3.pm. BECAUSE AT 3.45pm A VISITOR FR ADDENBROOKE RES. HOME COMPLAINS TO STAFF NURSE THAT Code A WAS DEHYDRATN AND IN A HEAVILY SEDATED CONDITION. SO FROM 3.p.m IN LESS THAN ONE HOUR Code A CAN DETER-

PORTSMOUTH HealthCare NHS TRUST

(f) *Your mother's dehydration on Dryad Ward*: As Mrs. Purnell's condition deteriorated, her ability to take oral fluids fluctuated. Fluids were, however, given when she was able to take them. Whether or not to commence subcutaneous fluids when a person becomes unable to take sufficient oral fluid, towards the end of their life, is not a simple decision. This links with decisions about treatment as explained in (b) above. Your concerns about this issue have already been throughly addressed during your meeting with Dr. Reid and Mrs. Robinson. There is simply nothing more we can add.

IT COULD BE EXPLAINED AS TO WHY SUE WAS DEHYDRATING SO SOON AFTER BEING ADMITTED TO W/M. HOSPITAL

If you remain dissatisfied it is important to identify what further steps the Trust could take to resolve your concerns. In one last attempt to conclude matters under local resolution, I would gladly arrange for an independent medical opinion from outside the District on the key issue of the appropriateness of the morphine administration. Alternatively you may choose to move on to the next stage in the NHS complaints procedure by requesting an Independent Review or, indeed, going straight to the Ombudsman. Back in December 1998 I sent you copies of two leaflets which explain how the NHS complaints procedure works. I enclose further copies for your information.

WHICH IS BEST THAT IS MY QUESTION

I would be grateful if having considered these options you would let me know within the next month if there is any further action you would wish me to take, otherwise we will consider the matter closed.

Yours sincerely,

Code A

Max Millett
Chief Executive

[redacted] 2

Replied to 24-6-99

Code A

19-7-99

Dear Sir,

Please find enclosed a photo copy of your letter dated 24th June. I have made a number of comments on the pages which I would like you to read.

It would be appreciated if you could arrange for an independent medical opinion from outside the district as we seemed to be at loggerheads on two key issues. One of course being A the morphine question regarding amount given and in light of my mother's condition on being admitted to the War Memorial why was it given to her at all.

The other points being E & F and more so F in that no satisfactory reason has been given for not treating the dehydration on the 17th Nov 1998 until it was pointed out to the duty staff that my mother was infact dehydrating. Also why no member of staff noticed that she was.

You see we come back to no times or dates as in the case of A when you state that my mother was given morphine not simply for bed sores. I am not talking about when she was actually dying from the 23rd Nov1998 but from day one of her being a patient at the W.M. - the 11th Nov 1998. Why such a high dosage on the 12th and following days, a dosage more in keeping with someone suffering from a terminal illness and not someone who has just been transferred from one hospital to another with nothing more serious than healing bed sores and old age.

A lot of poppycock that is what I keep on getting and as for D I intend to pursue this further through other channels when the complaint regarding my mother is finally resolved.

Thank you for your help in arranging, as you put it, one last attempt to conclude matters under local resolution.

Yours sincerely,

Code A

M.E. Wilson (Mr)

PORTSMOUTH
HealthCare
NHS
TRUST

Mr. M. Wilson,

Code A

Our ref
MM/BM/YJM
Your ref

Date
1st October, 1999
Ext
Code A

Dear Mr. Wilson,

I am writing further to my letter of 6th August, 1999 now that I have received the report from Code A Elderly Care Services, Southampton. I enclose a copy for your information.

In my letter of 24th June, 1999 I suggested that obtaining a second opinion should be the conclusion of the local resolution of your complaint. You echoed this sentiment in your letter of 19th July, 1999. In view of Code A s conclusions I assume that you will not wish to pursue the matter further at this level but please contact me within the next month if there are any further steps you would wish me to take.

Yours sincerely,

Code A

Max Millett
Chief Executive

PORTSMOUTH HEALTHCARE NHS TRUST CENTRAL OFFICE

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

Southampton University Hospitals NHS Trust

Southampton General Hospital
Tremona Road
Southampton SO16 6YD

Telephone Code A

Ref: GFT/SMP

T Code A

16 September 1999

Mr M Millett
Chief Executive
Portsmouth Healthcare NHS Trust
St James Hospital
Portsmouth
PO4 8LD
For the attention of Code A

Dear Mr Millett

Re: Complaint regarding Mrs E I Purnell

Thank you very much for inviting my comments on two aspects of the care of the late Mrs E Purnell resulting from her son, Mr M E Wilson's continuing concerns. I have been through the notes in great detail and am happy to comment on the areas that you requested from my position as Clinical Director of a district Elderly Care Service.

Firstly the use of morphine. In my experience, it is frequently the case that elderly people, when transferred from an acute environment to a rehabilitation unit, become unsettled after transfer. This is partly related to the disruption and the anxiety of the new environment and also undoubtedly partly due to the physical stress of the journey itself. It is noteworthy that when Mrs Purnell was admitted to the Gosport War Memorial hospital, morphine was not written up straight away but after 24 hours a doctor was asked to assess her because she was in pain which was not controlled by the oral analgesics which had been given to her. These were the same analgesics that she had been given on transfer from Haslar and I think it is probably worth pointing out that Co-codamol is an opiate containing drug. As a result of the concern of the nurses and the doctor who assessed her the day after admission, a very small dose of an oral Morphine preparation was used. In fact, on analysing the drug charts it seems that over the subsequent week to ten days she was actually only given between 10 and 20 mgs of morphine per day. More often than not this was at night in order to help her sleep and was a perfectly appropriate response to the fact that the night nurses often noted that she was very uncomfortable at night. It is not clear exactly from where her pain originated, from her fracture site or from her pressure sores, but there is plainly concern within the nursing notes that she was in discomfort and it is known that the pain from pressure sores can sharply deteriorate when skin separation occurs

In my opinion, the use of morphine is entirely justified in any old person who is in pain. It is an easy drug to use because it is easily administered and more reliably absorbed and therefore much more immediately acting than some of the so called minor analgesics. Because its side effects are well recognised, it is not dangerous if used in appropriate quantities which I believe was the case here, and because it can induce a sense of well being, it often relieves a lot of the anxiety to which I have alluded.

Over the subsequent two weeks her need for pain relief was assessed regularly and she was still only receiving between 10 and 20 mgs Oramorph. On the 23 November Dr Lord's extremely good summary and proposed management plan in the notes makes it quite plain that at that stage the patient was in a very poorly condition, was hardly responding to any questions but was groaning in discomfort when disturbed. She made the then entirely justifiable decision to change the administration of morphine from oral administration to the use of firstly subcutaneous injections which are generally regarded as virtually painless and then subcutaneous infusion.

I suspect that it still may not be clear to Mr Wilson how little morphine his mother actually had. Whilst I recognise that as an elderly lady she would be susceptible to the effects of morphine, the small doses that she received until the first record of him becoming concerned on 17 November, would not be sufficient to explain her deteriorating state. Indeed on the 14, 15 and 16 November she received only 10 mgs of morphine at night which is a very tiny dose and is frequently used in many other situations in order to help sleeping. It is usually the case that the first dose of morphine is the most likely to cause drowsiness. He himself noted on 12 November how much brighter she was - even after the first dose of morphine at 14.05.

In summary I therefore believe the use of Morphine was entirely appropriate and that the amounts administered could not be considered excessive. At the time when a decision was made to change her to parenteral administration of the drug as opposed to oral administration, that decision appears to be entirely justified by the excellent documentation in the notes.

The second area for which you have asked my comments is the concern about dehydration. The question of dehydration is a particularly common and worrying one for all small rehabilitation units where patients are often frail and the culture of rehabilitation can sometimes mean that fluid intake is not measured. In this respect I do not believe that the Gosport War Memorial Hospital is any different to any other community rehabilitation unit. The Nursing care plan has recognised that her fluid intake was poor. Indeed this was alluded to by Dr Lord when she originally visited Mrs Purnell over at Haslar. By the 14 November the nurses had noted that her urine had become rather concentrated and the plan then and on the next day was to encourage fluids although fluid intake was noted still to be poor. It is certainly true that the nurses having failed to increase the patient's fluid intake to appropriate amounts on two successive days might have requested a doctor to consider subcutaneous fluids. However this would only have meant that that request would have been made on 16 November rather than the 17 November when a doctor was asked to see her, at which point of course her son also noticed that she was dry. However I am sure there is not a doctor at Gosport War Memorial Hospital every day, again in common with most other peripheral rehabilitation units, and I feel that there is no evidence presented in the notes which would suggest that fluid being administered by drip from the 16th would have made any difference at all to her outcome. In as much as it is possible to say from the records that I have seen, she continued to receive subcutaneous fluids, at least one litre in 24 hours for the next two to three weeks, which was an appropriate attempt to ensure that any deterioration due to dehydration was corrected and reversed. The fact that she did not improve at all with parenteral rehydration I think also goes to demonstrate the poorly state she was in was not due to fluid depletion.

In summary therefore I believe that the use of analgesia was appropriate both in terms of the type of drug and the amount used, especially in the early stages, and I feel that dehydration was noted by the nurses who took appropriate action in the early stages and there was not an unreasonable delay before starting her on alternative methods of fluid provision once oral rehydration was shown to be unsuccessful. It is very hard for me to criticise these two aspects of the management of this patient.

* INFERS THAT A MEMBER OF NURSING STAFF ASKED THAT A DOCTOR SEE MY MOTHER WHEN INFACT I NOTICED SHE WAS DEHYDRATING AND DEMANDED A DOCTOR EXAMINE

SEE CHRONOLOGICAL LIST FOR

Code A

I hope these comments are helpful. Please let me know if there is anything more I can tell you.

With best wishes.

Code A

REPLY TO MAX MILLETT DETAILING MY COMMENTS WITH RESPECT TO DR GILL TURNER'S REPORT 16-9-99.

RE-MRS.E.I.PURNELL

DR.G.TURNER'S LETTER

A letter was received by Mr.Max Millett of the Portsmouth Healthcare N.H.S. Trust dated the 16th September 1999. A photo copy of which I have in my possession. On the one I am enclosing with other correspondence I have placed letters in alphabetical order so as to highlight certain aspects of it and below you will see my comments with respect to eaoh one in order.

A. My mother was last given co-codamol at Haslar Hospital on the 5/11/98. Dr.G. Turner states that these were the same kind of analgesics that my mother had been given on transfer from Haslar Hospital. Now from the way she has worded this one could easily assume that my mother was being given co-codamol up to the very day she was transferred from that hospital. Misleading because Dr.G.Turner could have mentioned the actual date, but she did not. Why then did my mother suddenly need oral analgesics in light of the previous week whilst at Haslar Hospital she had no need of them.

B. I disagree about the amount of morphine given on the 12th Nov.98 (no dates again mentioned by Code A) as being small. 20mg was the amount so far as I can decipher the writing. They began giving my mother morphine less than 24hrs after being admitted to the War Memorial Hospital.

C. Dr.G.Turner goes on to say that the morphine was administered mostly at night in order to help my mother sleep. She doesn't though explain why 7 out of 15 amounts shown on the W.M. medical record were during the day between the hours of 0630 and 1810.

D. According to this letter the night nurses noted that my mother was uncomfortable at night (after being admitted to the W.M. she never got out of bed again and yet at Haslar she was relatively mobile in that she was sitting in a chair beside the bed and feeding herself, at least to some extent.) So in one day the W.M. staff can assess my mother as being that uncomfortable at night that their only solution is to give her morphine. It would seem from the morphine given to her that they wanted her to sleep in the mornings aswell. See 12th 14th & 15th Nov 98 for a start.

Re-Mrs.E.I.Purnell continuation of Code A letter of the 16th Sept.99.

E. Back to Haslar Hospital here because she wasn't in any pain during the last week as a patient there otherwise they would have given her some kind of painkiller wouldn't they. So how can Code A justify my mother being given 20mg of morphine the day after she was admitted to the War Memorial which was the 12th Nov.98. BUT most cleverly Code A has avoided mentioning any dates and instead said most broadly that the amount of morphine was entirely justified for any old person in pain. What amount because she doesn't mentioned any figure either and for what kind of pain. Bedsores? I have gone through umpteen medical books and nowhere does it advocate the use of morphine for bedsores.

F. Anything after the 17th Nov.98 is immaterial to my complaint as by then my mother was dying and I believe solely due to the amount of morphine given to her between and including 12th Nov.98 - 16th Nov.98. It caused the dehydration and on the 17th Nov.98 my mother was in a very poor state.

As for Dr.Lord's 'good summary' on the 23rd Nov.98 then this was the first time that she had seen my mother since being admitted to the War Memorial Hospital. As I said anything they did was immaterial the damage having been done way back on the 12th Nov.98 or least that was the start of it.

G. The first time I became really concerned was on the 14th Nov.98. See my chronological list of events please and as for the dates mentioned by Dr.G.Turner then kindly refer to the W.M. medical records as the morphine administered on the 14th & 15th was a.m. - 10.30 & 10.25 respectively. To help her sleep?

H. Misleading to the extent that anyone reading this could only come to the conclusion that someone on the nursing staff asked that a doctor see my mother. Refer if you will please once again to my chronological list of events.

I. The whole paragraph from where I'm sitting is beyond belief. I have to ask myself if she even bothered to read what I sent her. The nurses did nothing with regards to the dehydration until I caused such a ruckus about it that security was called. As for analgesics of any kind being used the day after my mother was admitted to the W.M. then how can Code A justify such amounts in light of the Haslar medical records.

I WOULD APPRECIATE IT IF YOU COULD SPARE THE TIME, NO HURRY, TO READ MY COMMENTS INTERSPERSED AMONGST THE PAGES.

E.2313/99-00

Health Service Commissioners Act 1993

Report by the Health Service Ombudsman
for England
of an investigation into a complaint made by

Mr M E Wilson
14 Chester Courts
Jamaica Place
Gosport
Hampshire
PO12 1TB

Complaint against: Portsmouth Healthcare NHS Trust

Complaint as put by Mr Wilson

1. The account of the complaint provided by Mr Wilson was that on 25 October 1998 his late mother, Mrs Edna Purnell, fell and broke her hip. Mrs Purnell was admitted under the NHS to Royal Hospital, Haslar (the first hospital), which is administered by the Ministry of Defence. While in the first hospital Mrs Purnell had an operation on her hip, after which she made a steady recovery. On 29 October Mrs Purnell was able to sit out of bed and by 3 November she could be pushed in a wheelchair to the hospital shop and cafeteria. By 6 November she was no longer taking painkillers and on 11 November she was transferred to Dryad Ward at Gosport War Memorial Hospital (the second hospital). The second hospital is administered by Portsmouth Healthcare NHS Trust (the Trust).

2. When Mr Wilson visited Mrs Purnell on 13 November he noticed that her condition had deteriorated. Mr Wilson believed that Mrs Purnell had been sedated. On 14 November Mr Wilson complained about the level of sedation his mother was under and on 15 and 16 November he noticed an improvement in her condition. On 17 November Mr Wilson noticed that Mrs Purnell was dehydrated and brought this to the attention of a nurse and asked that Mrs Purnell be put on a drip. The nurse informed Code A that a drip was not available, a dispute ensued, and Code A was asked to leave the hospital. On the following day the Trust's Code A

1

INCORRECT A NURSE FROM ADDINGTONBROOKS REST. HOME ARRIVED BEFORE ME TO VISIT Code A AND IT WAS SHE WHO TOLD ME THAT Code A

(A) WHY WERE MEDICAL RECORDS DESTROYED (SEE WITN No 6.) WHEN MY COMPLAINT WAS STILL ACTIVE FOLLOWING A MEETING IN FEB 1999. ESPECIALLY AS DAILY FLUID INTAKE WAS AN INTEGRAL ISSUE (SEE WITN No 20 Page 7) WITH REGARDS TO WHAT OCCURRED ON THE 11TH NOV. 1998. See my CHRONOLOGICAL LIST FOR THE EVENTS OF THAT DAY

was asked to review Mrs Purnell's treatment. As a result of this Mrs Purnell was given subcutaneous fluids. Mrs Purnell's condition continued to deteriorate and on 23 November instructions were given for diamorphine to be administered subcutaneously if required. Mrs Purnell died of bronchopneumonia on 3 December 1998.

MY MOTHER WAS GIVEN ORAMORPH & DICLOFENAC FROM 12/11/98 CONTINUOUSLY THROUGH TO 23/11/98. DON'T YOU SEE HER MEDICAL RECORDS? YOU COULDN'T HAVE

3. Mr Wilson had written to the medical director on 27 November 1998 complaining about the care Mrs Purnell was receiving at the second hospital. The chief executive of the Trust replied in January 1999 and Mr Wilson met the medical director in February. In September the Trust arranged for an independent clinician to review Mrs Purnell's care. Mr Wilson remained dissatisfied and requested that an independent review panel be convened to consider his complaint. The Trust's convener refused that request. WHAT WAS HIS REASONS FOR DOING SO. I KNOW BUT YOU HAVEN'T SAID HAVE YOU.

(A)

4. The matters subject to investigation were that:

(a) Mrs Purnell did not receive reasonable medical and nursing care after her transfer to the second hospital on 11 November 1998; and

(b) the doses of morphine administered to Mrs Purnell after her transfer to the second hospital were excessive.

Investigation

5. The statement of complaint for the investigation was issued on 25 May 2000. The Trust's comments were obtained and relevant papers were examined. Those papers included records of Mrs Purnell's care and treatment in the first and second hospitals, correspondence concerning Mr Wilson's complaint to the Trust, and the written observations of the consultant geriatrician (the consultant) responsible for Mrs Purnell's care while she was a patient in Dryad Ward. I obtained advice on the medical aspects of the complaint from one of the Ombudsman's professional advisers. Another of his professional advisers gave help with the nursing aspects. I have not included in this report every detail investigated, but I am satisfied that no matter of significance has been overlooked. BULLSHIT YOU DO NOTHING I DON'T THINK YOU ARE UP TO THE JOB.

6. The investigation was somewhat hindered as a result of the Trust being unable to supply all of the records relating to Mrs Purnell's care and treatment in the second hospital. In April 1999 the original records were sent for microfilming and

THIS WAS AFTER THE FIRST MEETING BETWEEN MYSELF & THE PORTSMOUTH N.H.S. TRUST BUT BEFORE THE SECOND. VERY CONVENIENT FOR THEM WASN'T IT.

DESTROYED MEDICAL RECORDS

HOW CAN A DECISION BE MADE IF YOU DO NOT POSSESS ALL OF THE FACTS.

destruction. The Trust's policy required some documents, such as temperature charts and daily fluid balance charts, to be destroyed without being microfilmed. As a result I had access to only those documents which had been microfilmed and I could not be certain what other documents existed before their destruction. The early destruction of the records was contrary to the Trust's own policy and went against official guidance. The Trust expressed their deep regret for what had happened and said that it was the only time such an error had been made. I return to this issue in my findings and conclusions.

Mr Wilson's evidence

7. In letters to the Ombudsman's office **Mr Wilson** wrote that he could see no reason, in the light of Mrs Purnell not needing morphine based drugs during the last week of her stay in the first hospital, why she was given such medication within 24 hours of being transferred to the second hospital. He did not accept the Trust's explanation that Mrs Purnell needed the medication because she had developed extremely painful pressure sores and had pain in her neck and back. Notwithstanding those problems Mr Wilson considered that the choice of medication was inappropriate and that his mother was given excessive amounts of oramorph and diamorphine (both of which contain morphine). His other main concerns centred around what he saw as a failure to try and help Mrs Purnell regain her mobility and a failure to ensure that she did not become dehydrated.

NO DATES WHY NOT

SO ON 11/11/98 A WEEK PREVIOUS THEY WERE NOT PAINFUL WHILST SHE WAS AT HASCAR HOSPITAL FOR SHE HAD NO NEED OF ANY PAINKILLING MEDICATION THEN SUDDENLY ON 12/11/98 FIRST DAY AT WM MEMORIAL SHE IS IN EXTREME PAIN. YOU ARE A PART SIR IF YOU AGREE GIVE THIS TO BE TRUE

The Trust's formal response to the complaint

8. In their formal response to the complaint the Trust commented as follows:

> 'We do not consider that Mr Wilson's complaint is justified and wholly reject his previously stated claim that Mrs Purnell was "helped on her way". We do recognize, however, that we may have failed Mr Wilson by not helping him to a better understanding of his mother's prognosis. In the course of our investigation, a number of areas where practice could be improved were highlighted. We do not believe, however, that these areas contributed to Mrs Purnell's deterioration nor to her subsequent death. This view was upheld by [the independent clinician who reviewed the complaint in September 1999].'

X INDEPENDENT A JOKE! IT WAS THE SOUTHAMPTON N.H.S TRUST

After commenting on individual aspects of the complaint the Trust gave details of the areas of practice which, following the meeting in February 1999 between Mr Wilson and the medical director, they had undertaken to review. They were:

SEE NO 1 BELOW REGARDING WHAT WAS SUPPOSEDLY SAID TO ME. A LIEUTENANT WITH A WITNESS PRESENT SAID THAT IF DURING THE OPERATION (BY GENERAL ANAESTHETIC) MY MOTHER SUFFERED A CARDIAC ARREST THEN THEY WOULD NOT GO ALL OUT TO RESUSCITATE HER DUE TO AGE ETC. AND HE DID EMPHASIS THAT HEART MIGHT NOT BE ABLE TO TAKE SUCH AN OPERATION. THE WAY THIS REPORT HAS WORDED IT MAKES IT APPEAR THAT THE DOCTOR MEANT AFTER THE OPERATION NOT AS HE MEANT IT - DURING THE OPERATION.

admission protocols, including support for relatives; pain control; fluid protocols; and medical cover during weekends and bank holidays.

↑ LOST THE BLOODY RECORDS DIDN'T THEY SORRY! DESTROYED THEM.

Mrs Purnell's clinical and nursing records

9. Entries in the clinical and nursing records relating to the time Mrs Purnell was a patient in the first hospital include a post-operative instruction indicating that she should be helped to regain mobility as soon as possible. Another entry, made on the day of Mrs Purnell's hip operation (26 October 1998), records that a doctor had spoken to Mr Wilson and told him she was unlikely to recover. Over the next few days Mrs Purnell's condition fluctuated a little. On 29 October it was recorded that she was chesty but felt better after sitting up in a chair. The next day there are entries in the nursing records indicating that Mrs Purnell's heels and sacrum were red. On 31 October a nurse recorded that she was much improved and had tried to walk but with little success. Her pressure areas continued to be a cause for concern and on 2 November, when a doctor recorded a 'dramatic improvement in her general state', there is a note that the area around her sacrum was deteriorating.

10. On 3 November the records show that a referral was made to the consultant for her advice on Mrs Purnell's future management. In a note to the consultant a doctor wrote that Mrs Purnell was 'sitting out and beginning to mobilise', but the nursing records for that day included an entry stating that 'mobility remains poor'. After seeing Mrs Purnell on 5 November the consultant wrote:

> '.... [Mrs Purnell's] son and daughter-in-law were present when I visited and I have pointed out to them that rehabilitation was going to be very difficult given her mental state and pressure sores. They have agreed to a month's gentle rehabilitation in a NHS continuing care bed for a month initially. Unless there is a dramatic improvement .... I feel she will need a nursing home'.

626 NEVER ANY REACTIONS

GIVING MY MOTHER 'GENTLE REHABILITATION'. ! YOU KNOW IT & SO DOES EVERYONE ELSE.

The nursing records for the remainder of Mrs Purnell's time in the first hospital show that, despite regular attention to her pressure areas and the use of a special mattress, by the time of her transfer to the second hospital the sores on her heels had blackened and she had a sore on her right elbow. Other entries indicate that during the latter part of her stay in the first hospital the staff there were experiencing difficulty maintaining a satisfactory fluid balance. She also had oedema (an accumulation of fluid) in both legs and her left arm.

WHY DID THE WAR MEMORIAL STOP GIVING HER MEDICATION FOR THIS.

I WOULD LIKE BOTH THE HOSPITALS TO PRODUCE RECORDS TO SUBSTANTIATE WHAT HAS BEEN SAID ABOUT REGARDING BED SORES BECAUSE WHEN MY MOTHER WAS FIRST ADMITTED TO THE WAR MEMORIAL THE BANDAGES WERE REMOVED AND ONLY A USW DRESSING APPLIED. LATER FURTHER BANDAGES WERE ADDED BUT TO HER KEVIN LOOKING THROUGH A FAMILY ALBUM

See No11. THIS WAS GIVEN PRIOR TO MY MOTHERS OPERATION THIS SECTION IS MOST IMPORTANT WHEN COMPARING WHAT IS SAID WITH RESPECT TO AMOUNT OF MORPHINE ADMINISTERED AT NASLAR HOSPITAL WITH THAT GIVEN TO HER WITHIN LESS THAN 24 HRS AFTER HAVING BEEN ADMITTED TO WEX MEMORIAL HOSPITAL.

11. The prescription and drug administration records in respect of Mrs Purnell's stay in the first hospital show that on 25 October she was prescribed morphine, 10 mg to be given as required. Only one dose was given, at 1.15am on 26 October. A prescription was also written that day for up to two tablets of co-codamol to be given as required. (Co-codamol is a proprietary non-opioid drug used for pain relief – it does not contain morphine.) Mrs Purnell was given co-codamol 14 times between 25 October and 5 November, but none after that. Between 6 and 11 November she was given no pain relief medication other than aspirin.

WHAT DOES THIS SAY THEN REGARDING WHAT HAPPENED ON THE 12TH NOV 98 AT THE WEX MEMORIAL HOSPITAL

12. The prescription and drug administration records in respect of Mrs Purnell's stay in the second hospital include a prescription dated 11 November authorising the administration of co-codamol, if required; Mrs Purnell was given two tablets at 8.30am the next day. Later on 12 November a doctor wrote a prescription for 2.5 mls to 5 mls oramorph (a solution that would have contained 5 mgs to 10 mgs of morphine) to be given orally, as required, at intervals of four hours or longer. That afternoon, Mrs Purnell was noted to be in a great deal of pain and was given 2.5 mls of oramorph at 2.05pm. She was given a further 2.5 mls at 6.30pm and 5 mls at 10.37pm. The two evening doses were given after nurses observed that Mrs Purnell was still in pain.

X DOES NOT EQUATE TO AMOUNTS MORPHINE & MY THEN WAS GIVEN.

XX 20 MG IN TOTAL BETWEEN 14.05 HRS AND 22.37 HOURS.

13. Between 13 November and 24 November Mrs Purnell was given a total of 15 further doses of oramorph. No dose exceeded 5 mls and she was never given more than two doses in one day. On 24 November, a doctor wrote a prescription for diamorphine to be given subcutaneously on a regular basis. Mrs Purnell was given 20 mgs of diamorphine each day between 24 and 30 November. On 1, 2 and 3 December she was given 40 mgs each day. The nursing records indicate that Mrs Purnell was in pain on the day she was admitted to Dryad Ward and there are many subsequent references to her being in pain and needing pain relief to help her sleep at night.

XXX BY THE 24TH MY MOTHER WAS IN A COMA.

14. On 14 November the ward manager recorded at 4.30pm that Mr Wilson had expressed concerns about the amount of sedation being given to his mother. On checking Mrs Purnell she was described as 'rousable but not very communicative'. She had been given 2.5 mls of oramorph at approximately 10.35 am that day. The ward manager's note continued:

PLEASE SEE MY CHRONOLOGICAL LIST DATES OF EVENTS. PERTAINING TO 17TH NOV 98 NO 16 BELOW. WITNESS ON MY BEHALF IS A NURSE WHO NOTICED THAT MY MOTHER WAS DELIBERATELY.

'[Mr Wilson] is aware of [Mrs Purnell's] poor prognosis [and] .... that she may need opiates to control her pain [and] he agrees to this'.

15. An entry made by one of the doctors who attended Mrs Purnell referred to a conversation which she had had with Mr Wilson during the evening of 17 November. She wrote:

* WHAT I SAID WAS (I HAVE WITNESS TO THIS) THAT DR/AD WHO WAS THE KILLING FIELDS OF THE W.M. HOSPITAL.

'[Mr Wilson] seen. Very angry. Feels his mother is not being cared for adequately, is accusing nursing staff of* murdering his mother by giving her oramorph .... She is clearly in distress when moved e.g. for washing/dressing and as such does require analgesia (Mr Wilson is not happy for her to have any analgesia). She is clearly also very poorly and I do not feel any active intervention is appropriate ....'

* I DEMANDED TO SEE A DOCTOR AND WAS CONSEQUENTLY ASKED TO LEAVE THE HOSPITAL BY THE SECURITY STAFF.

After discussion with the consultant the doctor concerned wrote a prescription for Mrs Purnell to be given fluids, subcutaneously (under the skin).

CONTRADICTION HERE See Section 2 Page 1+2. WHICH STATES NOT DAY 18TH Nov 98.

16. A slightly later entry, in the nursing records for 17 November, referred to a conversation which one of the nurses had with Mr Wilson. She wrote:

'Mr Wilson expressed his dissatisfaction with the treatment at [the second hospital]. He was concerned his mother was nursed in bed, did not have [intravenous fluids] in progress and had been given oramorph.

'Explained she was in bed because she had pressure sores on admission and was nursed on a pressure relief mattress.

'That I did not comment on the use of [intravenous] fluids as it was not my area of practice and that oramorph was used as Mrs Purnell was in pain. Mr Wilson was verbally abusive to myself and the doctor ....'

In a further entry the nurse wrote that Mr Wilson had requested, and been given, a complaints form before leaving the ward and saying that he would not be coming back.

* I ONLY RETURNED ONCE AFTER THIS TO SEE MY MOTHER SHE WAS IN A COMA. I HAVE WITNESS THAT I NEVER SPOKE TO ANY MEMBER OF THE NURSING STAFF. YET IF YOU REFER TO SOLICITORS LETTER THEN I HAD BEEN IN CONTACT WITH

17. Another entry that evening, by the hospital's medical director, records that if Mrs Purnell continued to be in pain or distress she should be given pain relief,

MEMBERS OF THE STAFF RESCUING THAT TO QUOTE LETTER 'I WAS HAPPY FOR THE SOLICITOR TO MAKE FUNERAL ARRANGEMENTS

despite Mr Wilson's wishes to the contrary. Because Mrs Purnell was incapable of making decisions for herself the staff should act in what they believed to be her best interests. In order to increase Mrs Purnell's intake of fluids the medical director approved their administration, subcutaneously, for between five and seven days, to see if her condition improved. In doing so, he expressed concern that, in view of her general condition, giving fluids might not be appropriate. The medical director returned to the ward at 8.00am the next day in order to check on Mrs Purnell.

[redacted]

18. The next day, 18 November, a nurse wrote that staff and the police had tried to contact Mr Wilson but that he was not at either of the addresses in the hospital's records and the telephone number in the records was unobtainable.

X NEARLY TWO WEEKS BETWEEN ASSESSMENTS SOME CARE

19. As at the first hospital, the staff at the second continued to nurse Mrs Purnell on a special mattress designed for patients with pressure sores, or at risk of developing them. Her Waterlow score (giving an indication of the degree to which her pressure areas were at risk) was assessed on 11 and 23 November. Her scores on both those dates identified her pressure areas as being at very high risk. Staff also assessed her level of dependency on those days. She was incontinent of urine and faeces, and was totally dependent on staff for bathing, dressing and grooming. On 11 November she was described as needing help to feed herself but by 23 November she was unable to do so at all. With regard to her mobility she was assessed on both occasions as being completely dependent on others, unable to stand, and unable to transfer (e.g. from her bed to a chair) without a hoist.

X AFTER AMOUNT Morphine GIVEN I ONE WOULD BE ABLE ANYTHING FOR THOSE

20. On 11 November a care plan was produced with details of the action that was to be taken to address Mrs Purnell's needs. Among other things she was to have regular mouth and pressure area care, be encouraged to take food and fluids, and receive adequate pain relief at night. Documents recording the care that was given indicate that her mouth care and personal hygiene were attended to daily. There are entries, on 14 November and 17 November (before Mrs Purnell was given subcutaneous fluids) recording that her urine was either dark or concentrated, and that she was to be encouraged to drink more fluids. Corresponding entries elsewhere in the records indicate that on 13 and 14 November Mrs Purnell could manage only small amounts of food and fluids and that staff continued to encourage them after 17 November, when fluids were being given subcutaneously. There are specific entries relating to pressure area care given on 13, 14, 20 and 22 November, and to Mrs Purnell being turned and encouraged to lie on her side. On other dates

WITHOUT THE FOOD & FLUID INTAKE RECORDS HOW WOULD YOU KNOW WHAT MY MOTHER WAS GIVEN.

WITHOUT MY INTERVENTION WOULD SHE HAVE BEEN GIVEN FLUIDS

nurses recorded that care was given fully in accordance with the nursing care plan. The plan included instructions on how Mrs Purnell was to be moved and on the care and treatment of her pressure areas.

THE WOMAN IS AN IDIOT.

Advice of the Ombudsman's Professional Advisers

21. The Ombudsman's medical adviser, Code A, M.B., B.S., F.R.C.A., a consultant anaesthetist with wide experience in an acute pain team and in palliative medicine, commented as follows: DR ANN NAYLOR MUST BE LIVING IN CUCKOO LAND INACCURACIES THROUGHOUT HER STATEMENT.

'Having reviewed the clinical and nursing records on the complaints file, I consider that the choice of pain relieving drugs for Mrs Purnell was appropriate in terms of the type of drug, doses, methods of administration and frequency of administration. Staff were correct in their judgement that Mrs Purnell required palliative care (active total care for a patient whose disease is not responsive to curative treatment). The drugs and doses used are within the ranges recommended in the BNF (British National Formulary) for palliative care. There is no evidence that Mrs Purnell received excessive doses of morphine. X SINCE WHEN IS AN OPERATION TO REPAIR A BROKEN HIP A DISEASE.

'In my view, the same comments could be made about the management of Mrs Purnell's hydration. When Mrs Purnell was admitted, she was able to take small amounts of fluid and food with assistance. There is no evidence that Mrs Purnell was not sufficiently encouraged to drink during her first week on Dryad Ward. Over enthusiastic attempts to encourage a patient to drink can be very disturbing and not in their best interest. When her condition deteriorated, an appropriate regime of subcutaneous fluids was instituted. Earlier use of subcutaneous fluids would have made no significant difference to the outcome.

THERE IS NO EVIDENCE EITHER WAY IS THERE. IN THE MEDICAL DOCS THERE ISN'T.

'Following the fall when she broke her hip, Mrs Purnell did not regain mobility. She was able to sit out of bed with assistance and at one time was fit to sit in a wheelchair. There is evidence of the staff having kept this aspect under regular review and I am convinced that all was done that could be done to increase Mrs Purnell's mobility. Given her age, her general physical and mental health, and her recent fracture, sadly it was impossible to improve her mobility and she developed pressure sores which made attempts at mobilisation considerably more difficult. Prior to her admission to

SLIGHT DEMENTIA.

hospital, Mrs Purnell had been living in a nursing home and on admission to hospital she was noted to have senile dementia, oedema of the legs, pressure sores, urinary and faecal incontinence and to require full assistance with the activities of daily living. The plan had been for slow rehabilitation, although the likely limited effect of this was recognised and this proved to be the case.

'Conclusion

Mrs Purnell made a steady recovery after breaking her hip in a fall. She was not mobile and her condition gave cause for concern that she might prove difficult to mobilise. After her transfer to the second hospital she developed pressure sores, mainly as a consequence of her immobility. Code A SHE ALREADY HAD PRESSURE SORES AT HASLAR HOSPITAL

'She was treated with care and compassion and due to severe pain from her pressure sores required the use of morphine. At a later stage, when she became dehydrated, appropriate measures were used to treat this.

DESCRIBED WHAT KIND OF PRESSURE SORES SHE HAD

MORE BULLSHIT *'Mrs Purnell received medical management entirely appropriate to her condition and prognosis and this was supported by the nursing care plan.'*

SUPPOSEDLY SHE WAS TRANSFERRED TO THE WIN MEMORIAL ACCORDING TO HER MEDICAL NOTES FOR GENTLE REHABILITATION

22. The Ombudsman's nursing adviser reviewed the papers and concurred with the views of the medical adviser where they overlapped with issues concerning Mrs Purnell's nursing care. She commented that Mrs Purnell's pressure sores would have been acutely painful, particularly during the early stages of their development. The records provided evidence of the nurses having formulated a timely nursing care plan following Mrs Purnell's arrival in Dryad Ward. In so far as it was possible to judge (owing to the lack of fluid balance charts and some of the other records), Mrs Purnell's care appeared to have been delivered as required by the care plan. The drug administration records showed that at all times the nurses administered Mrs Purnell's medication in accordance with the doctors' prescriptions.XX

X

XX NO PRESCRIPTION FOR DICLOFENAC WHICH SHE WAS GIVEN ON 16/11/98.

X HOW THE HELL WOULD YOU KNOW WITHOUT THE SO CALLED INADVERTENLY DESTROYED RECORDS.

Action taken by the Trust

23. The Trust provided details of the areas where they had reviewed their written policies as a result of Mr Wilson's concerns. Although they had not upheld Mr Wilson's complaint their investigation had highlighted issues that needed attention. Work had been done on an admissions policy for the ward. The policy defined more closely the categories of patients to be admitted to Dryad Ward and required a nominated member of the nursing staff to liaise with relatives before formulating

the nursing care plan. There was now an agreed policy for the prevention and management of malnutrition, under which every patient was assessed on admission to ascertain the degree to which s/he was at risk of malnutrition and to help identify the appropriate nursing interventions. A multi-professional policy was also being prepared for the assessment and management of pain, with patients' needs being reviewed on a regular basis. In addition to that the Trust had introduced new forms for the prescribing and administration of drugs using a syringe driver (an automated device for delivering a preset dose of medication). Since February 1999 consultant cover on the ward had been increased from one ward round every fortnight to one every week.

Findings

24. The Ombudsman's medical adviser has stated that in her opinion the medical management of Mrs Purnell was appropriate, having regard to her condition and prognosis. I see no reason to believe otherwise. In caring for Mrs Purnell the staff had to strike a balance between doing all they could to facilitate her rehabilitation (as long as that remained an option) and not doing anything that would cause her unnecessary suffering. I believe they approached Mrs Purnell's management in a considered and professional manner. Sadly, Mrs Purnell's prospects of recovery were very poor. That was explained to Mr Wilson while his mother was in the first hospital, and after she was transferred to the second. * IF THIS WAS THE CASE. THEN WHY SAY THAT SHE WAS GOING TO THE W.M. HOSPITAL FOR GOING REHABILITATION.

25. Because some of the records were destroyed prematurely – an error for which I criticise the Trust – my findings in respect of the nursing care are based only on the documents which are still available. Although incomplete, the records provide evidence of the nurses having systematically assessed Mrs Purnell's needs, formulated a care plan, and delivered that care. Their approach was also influenced, to a large extent, by Mrs Purnell's poor condition and prognosis. I accept that, in view of her general condition and the pain she was in, it would not have been appropriate to have tried any harder to increase her mobility. I also accept that the staff did all they reasonably could to maintain Mrs Purnell's nutritional intake. The medical director was right in pointing out that the staff should act in what they considered to be Mrs Purnell's best interests, despite Mr Wilson's objections.

WHY AT RELIVES HOW CAN YOU JUST ACCEPT WHAT THEY TOLD YOU.

26. Central to Mr Wilson's concerns was his belief that the medication his mother was given was excessive. In his correspondence with the Trust he placed much emphasis on the fact that she had needed no pain relief during her last week in the

THE DAY AFTER BEING ADMITTED SHE WAS IN GREAT PAIN THEN WHY TRANSFER HER FROM HASLAR IF SHE WAS IN SUCH PAIN.

first hospital. I can see how it might have appeared to him that the second hospital were giving Mrs Purnell more medication than she needed; however the records show clearly that she was in a great deal of pain and that pain relief was essential for her comfort. As for the choice of oramorph and diamorphine, the dosages prescribed, and the frequency of administration, the Ombudsman's medical adviser has commented that those were appropriate in the circumstances. I see no reason not to accept her view.

X I DON'T THINK YOU HAVE THE SAVVY TO MAKE A DECISION ON YOUR OWN.

27. In their formal response to the complaint the Trust commented that they may have failed Mr Wilson by not helping him to a better understanding of his mother's poor prognosis. It appeared to Mr Wilson that his mother was improving up to the time she was transferred to the second hospital. His hopes may have been heightened by the consultant's plan 'for a month's gentle rehabilitation' and the prospect of her eventually going to a nursing home. It is entirely understandable, therefore, that he was greatly upset by the changes which followed so soon after Mrs Purnell's move to the second hospital. It seems, however, that when he raised his concerns on 14 November, the nurse to whom he spoke believed that she had reassured him. It was only later, on 17 November, that the full extent of his feelings became apparent, and for a time after that the staff were unable to contact him. In the circumstances I consider that the staff probably did all they could to try and help Mr Wilson understand matters.

[redacted]

28. To sum up, I have not found evidence of unsatisfactory medical or nursing care, and I am satisfied that Mrs Purnell was not given excessive doses of morphine. I do not uphold the complaints.

IF YOU WISH I WILL SEND YOU EITHER SOME BLINKERS OR A GUIDE DOG. ALL YOU ARE DOING IS TAKING DR ANN TAYLOR'S WORD FOR IT AREN'T YOU.

Conclusions

My findings are given in paragraphs 24 to 28. I have not upheld the complaints. However, I hope that the Trust's actions following Mr Wilson's complaint to them will reassure him that his concerns have resulted in improvements being made. I have been told by the Trust their procedures have also been improved to ensure that errors in the selection of records for microfilming are picked up before the records are destroyed. In addition to that the Trust have extended their microfilming

contract to include fluid charts and other items of clinical relevance which were not previously filmed. I regard that as a satisfactory outcome to my concerns about the premature destruction of some of the records in this case.

Code A

duly authorised in accordance with
paragraph 12 of Schedule 1 to the
Health Service Commissioners Act 1993

22 March 2001

Code A

PO12 1TB
7/Jan/02

Dear Mr. Code A

I doubt very much if you recall anything about this report that you wrote and so are possibly wondering not only as to why I am writing to you but also what has taken me so long to getting around to doing so because it has been awhile hasn't it.

Well I always did intend to reply to your rather limp effort but then what was the hurry after all I had already come to the conclusion after reading through it that I had drawn the short straw when they assigned you the task of compiling said report.

The sad thing is you could have done everyone who unfortunately has experienced what the War Memorial Hospital calls 'care of their patients' a great service in our attempts to obtain such 'care' as the elderly deserve. You held a trump card in that the Portsmouth N.H.S.Trust had supposedly inadvertently destroyed vital medical records and not the first time they had either even though they said it was. Please see the photo copied enclosed page from a Mrs.G.Mackenzi Ves letter as the same thing occurred in her case and her mother died four months before mine.

Surely though you didn't really believe that my mother's records really were the first they had destroyed did you?.

Anyway because they had been then you could have said in your report that due to the lack of these records that you were unable to make a decision one way or the other regarding either upholding my complaint or rejecting it. An impasse so to speak thereby being fair to both parties involved, namely the Portsmouth N.H.S.Trust and myself.

In your findings on PAGE 10 of your report you say that you had no reason to believe otherwise with regards to what the Ombudsman medical asviser stated. I would love to know just what you did contribute to the twelve page report. Not much from what I can gather for you seem to rely in the most part on what a Dr.Ann Taylor has said. Further to this whatever the W.M.H. has said you have taken as gospel inspite of medical records having been destroyed.

Would it be true to say that you have weaved your report around what the W.M.H. has said and of course what Dr.Ann Taylor has put in her report. Not that I blame you if you have easiest way out really.

What else am I supposed to think when you never contacted even one witness who was willing to testify on my behalf as to what they saw at the W.M.H. There was a qualified nurse and three qualified residential care workers who would have been quite happy to have given you their honest version of events whilst they were visiting my mother. But no, you choose to believe whatever the hospital told you.

Had you of taken off your blinkers you might have seen a lot more because something has been going on in that hospital and someone is responsible for destroying at least three lots of medical reports that I know of. It was no accident. Once maybe, twice perhaps but three times whilst each were in the process of a complaint against the Portsmouth N.H.S.Trust, no way. No doubt there are others aswell, records that is, which have very conveniently found their way to the furnace.

Take a look at PAGE 2 Section 6 of your report. The records were destroyed in April 1999 this was just after the first meeting that was held between myself and the Portsmouth N.H.S.Trust with Dr.Reid in attendance aswell. Another meeting had been originally planned for June so there must have been something in the records that they did not want to become public knowledge and so purposely accidently destroyed them. If what ever was stated in them was in their favour they would have taken good care of them wouldn't they.

I have listed in numerical order page by page and section by section parts of your report that I felt it was necessary to comment on. I would appreciate it if you could spare the time to read through them, take your time as there is no hurry. You will no doubt disagree with what I have said but I trust you will respect my right to say what I have, but most importantly and first of all if you will please read the enclosed photo copies of the W.M.H. medical reports and what a Dr.Barton said on the 20/11/98 about being 'happy for the nursing staff to confirm my mother's death' and repeating it word for word again on the 28/11/98. This is on pages 4 & 5 section four of the W.M.H. medical reports.

In closing this letter I would just finally like to say that the reason for enclosing photo copies of newspaper clippings is that to let you know that the problems within the War Memorial Hospital have still not gone away. Which brings me back to what I said about it being a pity that you did not dig a little deeper with regards to my mother's case. You might have made quite a name for yourself had you of done.

Anyway I trust you will not just bin what I have sent you to read, shame if you do without first reading through everything after all none of us are above learning from our mistakes. Not that I am applying that you have made one, but it is just that I think you should have at least taken a statement or two from those who were willing to testify on my behalf instead of what you did do which was completely ignore the fact that I had any in the first place.

If you do bother to read what I have sent you then I thank you for doing so.

Yours sincerely,

Code A

M.E.Wilson (mr)

PAGE 1 SECTION 2 line five.

Had you of bothered to read my chronological list of events for the day Tuesday 17th November 1998 you would have read that a nurse from Addenbrookes Res. Home arrived before me to visit my mother and it was she who told me that my mother was dehydrating. You never spoke or wrote to any witness that was willing to testify on my behalf as to what they saw going on at the War Memorial hospital and instead took whatever the W.M.H. said as gospel. This being the first of many inaccuracies on the part of the W.M.H. nursing staff's account as to what occurred on various days whilst my mother was a patient in this hospital.

PAGE 2 SECTION 3

The reason for a Code A refusing my request is that he came up with the lame excuse that because I had stated in a private letter to Dr.Reid (in answer to one from him) that I hoped my complaint would eventually end up in the hands of the Crown Prosecution Service, that this could be contrued as I now intended to seek legal advice. Nowhere during the course of my complaint had I ever mentioned going to a solicitor and infact I always adhered to the correct procedure for making such a complaint. To prove just how unindependent the covener is Dr.Reid must have given my private letter to him to this Mr.Lee to read. It was not a part of my official complaint because it was simply a personal letter to Dr.Reid. They knew that it was but tried to make something out of it to the extent that in the end they did by refusing my request for an independent review. Not that it mattered because I then realised that it would not have been that independent would it.

PAGE 3 SECTION 7

Either you are stupid or you think I am, probably the latter. How though could the pain (bedsores) deteriorate to such an extent that from needing no pain-killing medication just prior to being transferred to the W.M.H. and then requiring 20mg of oramorph in 8½ hours just 24 hours later. Not possible, you know it and so do I along with the nursing staff on duty that day at the W.M.H. in Dryad Ward.

PAGE 4 SECTION 9 lines three, four and five.

But this is not true. No doctor spoke to me regarding my mother in the long term not recovering. What was said by the RAF doctor to me was infront of a witness (my ex-wife) that if my mother whilst under the anaesthetic to repair her hip began so to speak 'go downhill' that is her heart was drastically weakening they would not go all out due to her age and health in general to resuscitate her. I agreed to this because as I replied to him my mother had lived a very full and interestingly rewarding life. The wording in your report though reads as if I was told that my mother was unlikely to recover even if the operation (which it was) turned out to be successful. Neither of us have anything to substantuate what was said by I do have a witness whilst you do not have one.

PAGE 4 SECTION 10 begin line six.

Contradiction refer back if you will please to above section your line five 'unlikely to recover'. Now I am being told that even though rehabilitation was going to be difficult and also unless there was a dramatic improvement in my mother's condition then she would need a nursing home. Nothing about not recovering is there. Tell me didn't you read what you were writing because if you did then why didn't you think it odd that in one breath my mother was in the long term unlikely to recover and in the next at worst she would have to settle for a nursing home. Bloody big difference between not recovering at all isn't it.

PAGE 4 SECTION 10 begin line seven.

Fluid balance. My mother had oedema then why did the W.M.H. stop giving her medication for this. Didn't you compare the Royal Haslar records with those of the W.M.H. You didn't ask why medication was stopped did you, infact you didn't ask much at all so far as I can see or rather read.

PAGE 5 SECTIONS 12 & 13.

Once again we are back to the morphine issue and nowhere according to Martindales book on drugs and the usage thereof does it mention morphine being used in the treatment for pain when it comes to bedsores. No one has really delved into the question of why she did not need such medication right up to the day she was transferred from Royal Haslar and yet before they hardly had time to close the doors behind her as she was admitted to the W.M.H. they were giving my mother morphine. Not logical no matter how hard they try to use the excuse of bedsores. You know I am right but you hadn't got what it takes to question the disparity between the using such a debilitating drug at one hospital and not at the other.

PAGE 6 SECTION 15.

Contradiction here. See pages 1 & 2 section 2 of your report which states the next day a subcutaneous drip was attached to my mother, the 18th November 1998. Not as it implies from the wording in section 15 'on the evening of the 17th November 1998 etc'.

Let us go back to what it says in section 2 pages 1 & 2 shall we. Start at the end of line 4. On the 17th November etc because the nurse informed me that such a drip was not available. Now continue on the last line on page 1 'the trust's medical director on the following day, which is now the 18th November 1998 reviewed the situation and because of this my mother was put on a drip. What I am trying to point out to you is that you took everything that the W.M.H. nursing staff said as gospel, but here I am showing you that discrepancies do exist. Why then didn't you question the fact that reports by various members of the staff on Dryad Ward did not match up.

PAGE 6 SECTION 17.

The medical director was infact Code A and a subcutaneous drip was attached to my mother on the 18th and not as it implies in section 15 page 6 last two lines and to quote them ' after discussion with the consultant (no names and my mother's consultant a Dr.Lord did not see her until the 23rd Nov.98 and previous to this the last time she saw my mother was at Haslar hospital) the doctor concerned wrote a prescription for Mrs.Purnell to be given fluids, subcutaneously.

Therefore to re-affirm this see page 7 section 20 of your report beginning on line 11 'after 17th November when fluids were given subcutaneously'. This means on the 18th November 1998 and not the evening of the 17th. Which also means on page 6 section 15 line 10 'wrote a prescription for Mrs.Purnell etc etc'. Now to page 6 section 16 lines 1 & 2 'a slightly later entry in the nursing records for 17th November 1998' this about a conversation with me where I mentioned my concern that my mother was not receiving fluids through the use of a drip. Those two lines completely contradict the last two lines in section 15. Tell me who was telling the truth. Well I was when I said in my chronological list of events day by day that it was the 18th November 1998. So if I was telling the truth then about what happened on the 17th & 18th November I could be telling the truth on the other days on my list BUT you would only listen to what the War Memorial hospital had to say.

PAGE 7 SECTION 19.

Stated in this paragraph is the fact that on the 11/11/98 needed help to feed herself but by the 23/11/98 she was unable to. Come on play fair noboby would be able to feed themselves even with help after nearly two weeks of continually being given morphine (apart from 17th when she was given 100mg of diclofenac, which is just as bad). What kind of state do you think my mother was in by then, a comatosed one, you would be spot on if you said that.

PAGE 7 SECTION 20.

Please see attached W.M.H. records section 4 page 3 which states that I could be arrested for a technical assault on my mother for encouraging her to eat. 17/11/98. Yet the W.M.H. are saying that it was alright for them to encourage my mother to eat on 13th & 14th Nov.98. Not that they made any real attempt to. The day when I actually did give my mother something to eat was the 16th Nov98 and she ate a whole tuna mayonaise sandwich. I have two people who witnessed this.

The state my mother was in on the 12th through to and including the 15th was such due to morphine administered to her that she couldn't or wouldn't open her eyes and as for eating anything, how could she being as she was in such a sedated state. My mother's waterflow score was assessed on 11th Nov the day she was admitted to the W.M.H. and not again until the 23rd Nov and yet she was seriously ill. Not what one could really call 'giving her much care and attention' is it by the W.M.H.

PAGE 8 SECTION 21.

Dr.Ann Taylor's report line eight. What is palliative care? Temporary relief. Note the word temporary but my mother was given morphine continually which meant then that she required permanent care. Do bedsores need such care, I think not. No one has ever asked why from the day after my mother was admitted to the W.M.H. was she given morphine everyday bar one, the 17th Nov. No one has questioned either why she did not need morphine when she was at Haslar hospital right up to the very day 11/11/98 that she was transferred to the W.M.H. No one has really done their job properly have they.

PAGE 9 SECTION 22 line six.

In so far as it was possible to judge you hadn't a clue, had you because the records had been destroyed. So why didn't you say this instead of just assuming. Sorry I forgot that you believed whatever the War Memorial hospital told you. I do apologise for this oversight.

No more to be said other than so far as I am concerned my mother was unlawfully killed and if the full facts were presented before a jury in an open court the verdict would be guilty on the morphine question alone.

HAMPSHIRE Constabulary

Paul R. Kernaghan QPM LL.B MA DPM MIPD
Chief Constable

Criminal Investigation Department
Police Headquarters
West Hill
Winchester
Hampshire
SO22 5DB

Our Ref. : HQ/CID/DCI 7410/2001

Your Ref. :

Tel. : 0845 045 45 45
Extn. : Code A

29th May 2001

Mr M.E. Wilson
14, Chester Courts,
Jamaica Place,
GOSPORT,
Hampshire.
PO12 1TB

Dear Mr Wilson,

Re: Portsmouth Health Care (NHS) Trust

I am writing to advise you that with effect from Monday 21st May 2001 the Senior Investigating Officer (SIO), in charge of the police enquiry into the circumstances of the death of a patient at the War Memorial Hospital (Gosport) on the 21st August 1998 and any other alleged criminal matters that may stem from this investigation, became Detective Superintendent John James.

Detective Superintendent James is based at the Major Incident Complex, Police Station, Kingston Crescent, Portsmouth, Hampshire PO2 8BU (telephone no. 0845 045 4545 ext. Code A Code A

The papers that you recently forwarded to me have been passed to the Major Incident Complex and I will be fully briefing Mr James on this and, indeed, all aspects of the investigation. I am sure that a member of the enquiry team will contact you very soon.

Thank you for the assistance given to me during my tenure as SIO.

Yours Sincerely,

Code A

Ray Burt
Detective Chief Inspector

This is a copy of a letter I sent to Det. Sup. James following the letter that I received on 29/5/01 from Det. Chief Inspector Burt.

14, Chester Courts,
Jamaica Place,
Gosport.
PO12 1TB
24/July/01

Dear Sir,

I have enclosed a photo copy of a letter that I received from Detective Chief Inspector R. Burt of the C.I.D. Winchester for you to refer to so that you know what I am talking about.

It has been two months now since you received all the papers pertaining to a complaint that I made against the Portsmouth Health Care Trust and having already gone through the recognised correct procedure for such complaints as mine.

I would now like to take it a stage further and the reason for doing so is that I fail to see how the Ombudsman came to the decision that he did in light of the fact that important medical records of my mother's were inadvertently destroyed by the Portsmouth H.C.Trust whilst my complaint was in it's infancy. They made a point of saying that this was the first time such a thing had happened and apologised for having done so.

Yet just recently I met a nurse whose mother died in similar circumstance to my mother and the Portsmouth H.C.Trust also destroyed some of her mother's medical records whilst her complaint was still active. So it wasn't the first time was it, not that I ever believed it was.

This nurse who has now retired from nursing and now owns a cafe in Stubbington is going to tell me more about what occurred and she did say that she still letters to substantiate what she had told me.

There is no need for me to go over the basis of my complaint the core of which is the amount of morphine administered to my mother, as you already have in your possession photo copies in full of my complaint against the Portsmouth H.C.Trust.

From all accounts you are at this very moment dealing with a complaint similar to mine against the Portsmouth H.C.Trust, but this particular person, a lady, did not follow the recognised procedure for such complaints as I did and with hindsight I wish I hadn't either. I have been informed that you are waiting for a decision from the C.P.S. on this case.

I would though appreciate it if you could tell me what I must now do regarding going through the same channels as this lady did so that the death of my mother can be investigated in an unbiased manner.

The brutal facts are with regards to my original complaint, all of which are in the papers that you have, how can a person have no need of any kind of a painkiller the week prior to being transferred from one hospital to another and yet at this second hospital this same person was given 20mg of morphine less than a day after being admitted and all in a space of 8½ hrs. You see according to the Martindale's book on drugs and the uses of, then unless someone was suffering from a terminal illness the amount given of 20mg is considered to be excessive.

Now had this person been that ill then they would not have been transferred in the first place to another hospital where supposedly it was just for gently rehabilitation prior to moving on to a nursing home. The hospital's words, not mind, as stated in the Ombudsman report.

In bringing ths letter to a close I will be guided by your advice as to how best, by taking a different path, I can approach the re-opening of my complaint because it does appear that the medical profession in this country is getting away shall we say with the genocide of the elderly. And we must not forget that we are getting older aswell and could face the same distressing end to our own lives as others already have and likewise we will also be helpless to do anything about it.

Yours sincerely,

M.E. Wilson. (mr)

FOLLOW UP WRITTEN TO ONE THAT I WROTE TO DET. SUP. JAMES ON 24/JULY/01. WHICH HE NEVER REPLIED TO.

14, Chester Courts,
Jamaica Place,
Gosport.
PO12 1TB
20/8/01

Dear Sir,

I have enclosed three photo copies that I would very much like you to read. One from Detective Chief Inspector Ray Burt dated the 29th May, another from myself to you dated the 24th July and finally the first and last page of a letter that Mrs.G.Mackenzie sent to me.

Before continuing I am still waiting for a reply from the letter I sent to you, but having said that I do appreciate the fact that a person in your position is very busy and no doubt in time someone in your department will eventually get around to replying.

Anyway the reason I am writing to you again is because of what Mrs.G.Mackenzie said in her letter to me, which I have underlined in red. You see according to a letter sent to me from the Portsmouth Health Care Trust the destruction of my mother's medical files pertaining to fluid and food intake records were a one off and they apologised for having done so. To quote their exact words 'it had never happened before'. Yet the same thing has happened before and probably many times before aswell that we do not know about.

Mrs.G.Mackenzie's mother had a hip operation at the same hospital (Haslar) as my mother. Likewise both were transferred to the War Memorial Hospital for, to quote again their words 'gentle rehabilitation' prior to moving on to a nursing home. Both were also given diamorphine almost immediately after being admitted to the W.M.H. so both case are on the face of it very similar.

What then can we deduce from this. Firstly the lies about the destroying of medical records, secondly lies regarding the gentle rehabilitation because otherwise thirdly why would they administer the amounts of diamorphine that they did so soon after being admitted to the War Memorial.

As I just said, very similar cases and both within a couple of months of each other. If this is not sufficient evidence to suspect that something is seriously wrong then for heaven's sake what does it take before one becomes suspicious as to what is going on at the W.M.H.

I would appreciate it if you could let me know whether or not you are going to pursue this matter any further which at the very least must be regarded as considering the evidence you already have in your possession, a prima facia case and therefore for the good of the community at large well worth looking into.

OR do you now consider our complaints against the Portsmouth Health Care Trust a dead duck so leaving us free to explore other avenues (such as our respective M.P.s) to try and expose what seems to be a convenient method of getting rid of the elderly.

In closing my letter perhaps it is suffice to say that it all comes down to turning a blind eye thereby saving the N.H.S. money with no feeling whatsoever on the part of those who could do something about it but won't, until that is it happens to one of their elderly relatives,

Yours sincerely,

M.E.Wilson. (mr)

Code A

HAMPSHIRE Constabulary

Paul R. Kernaghan QPM LL.B MA DPM MCIPD
Chief Constable

Code A

Major Incident Complex,
Fratton Police Station
Kingston Crescent
North End
Portsmouth
PO2 8BU

Our Ref. : MIC/DCI/PC/MK

Your Ref. :

Tel. : 0845 045 45 45
Direct Dial : Code A
Fax. :

24 August 2001

Mr. M. E. Wilson,

Code A

Dear Mr. Wilson,

With reference to your letter of the 20th August, I regret I was unable to find a telephone number for you.

Under the circumstances, it would be prudent that either I, or one of my team, come and talk to you personally.

Let me assure you that this enquiry is being taken very seriously indeed but it is a complex and sensitive issue. We are determined to ensure that the conduct of the investigation is appropriate, justified and has absolute integrity.

I am on Annual Leave now until the 10th September 2001. If you do not hear from anyone before this date, please contact me on Code A or Mobile Code A in order that we can arrange to meet.

Code A

P. E. CLARK
Detective Chief Inspector

Portsmouth HealthCare NHS
NHS Trust

Trust Central Office
St James' Hospital
Locksway Road
Portsmouth
Hants
PO4 8LD

Tel 023 9282 2444
Fax 023 9229 3437

Mr. M. Wilson,
14 Chester Courts,
Jamaica Place,
GOSPORT.
PO12 1TB

Our ref: MM/BM/YJM
Your ref:
Date: 14th September, 2001
Ext: Code A

Dear Mr. Wilson,

Thank you for your letter of 23rd August, 2001 requesting copies of your late mother's medical records.

× The full original document was, as you know, erroneously sent for destruction, prior to which the main medical and nursing notes were microfilmed. The photocopy of those documents is held in this office and I enclose a copy.

I have no knowledge of the letter from Mrs. MacKenzie to which you refer, but clearly some confusion has arisen in this regard. Gosport police currently have Mrs. MacKenzie's mother's notes and the Trust holds a copy.

I am not aware of any case other than your mother's in which the case notes have been destroyed in error.

Yours sincerely,

M. Millett pp

Max Millett
Chief Executive

I HAD ASKED FOR ALL OF MY MOTHERS MEDICAL NOTES.

HAMPSHIRE Constabulary

Paul R. Kernaghan QPM LL.B MA DPM MCIPD
Chief Constable

Major Incident Complex
Kingston Crescent
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Fax. : 023 9289 1562

15 November 2001

Mr M E Wilson
14 Chester Court
Jamaica Place
GOSPORT
Hampshire
PO12 1TB

Dear Mr Wilson

Reference: Gosport War Memorial Hospital

You will recall that you have previously been in contact with Hampshire Police concerning patient care at Gosport War Memorial Hospital. At this time our enquiries are not complete but I will advise you when they are finalised.

My purpose in writing to you is to draw to your attention an investigation being conducted by the Commission to Health Improvement into a range of issues concerned with Gosport War Memorial Hospital.

The manager for that investigation, Code A has asked me to write to you to advise you of their investigation in order that you may also contact them to discuss your concerns.

Code A can be contacted at the following address:

Commission for Health Improvement
12th Floor
Finsbury Tower
103-105 Bunhill Row
LONDON
EC1Y 8TG

Their telephone number is: 020 7448 9200
Their Fax number is: 020 7448 9222

HAMPSHIRE Constabulary

I will be writing to you again in the next few weeks to advise you of our intentions in relation to further investigations.

Yours sincerely

Code A

J JAMES
Detective Superintendent

Hampshire Constabulary
Police Headquarters
West Hill
WINCHESTER
Hampshire
SO22 5DB

Tel: 0845 0454545

Paul R. Kernaghan
QPM LL.B MA DPM MCIPD
Chief Constable

Code A

Your ref:

Our ref: CC/LR/smg/79.02

7 February 2002

Mr M E Wilson

Code A

Dear Mr Wilson

I am writing on behalf of the Chief Constable to acknowledge receipt of your letter dated 25 January 2002, concerning the Gosport War Memorial Hospital.

Mr Kernaghan has asked me to direct your correspondence to Detective Superintendent James so that he may address the issues you have raised, and arrange for a response in due course.

Yours sincerely

Code A

L Rickwood [Inspector]
Staff Officer to Paul Kernaghan
Chief Constable

LETTER SENT TO
PAUL A KERNAGHAN
CHIEF CONSTABLE
POLICE HQ WOLSTHIN
WINCHESTER
SO22 5DB.

Code A

25/Jan/02

Dear Sir,

I apologise for any inconvenience caused to your goodself by enclosing the photo copies because I do appreciate the fact that you are an extremely busy person and having accepted that then there is no need for that early a reply.

Really it is just a matter as to whether or not there is going to be any further investigations referring of course back to Detective Superintendent James letter of the 15th November 2001.

He did say that he would let me know, but then the letter that I received on the 24th August 2001 from Detective Chief Inspector Clark said that one of his team was going to speak to me personally, but they never have and that was last summer.

Anyway more importantly so far as I am concerned is what a Dr. Barton has said the medical notes that I have enclosed. What she has stated on Section 4 Page 4 dated 20/11/98 and then repeating the same thing on the 28/11/98 is very worrying indeed.

Still I don't want to bore you by going over it because I have said this and more in my letters to Detective Superintendent Clark much of which is regarding my concern over the morphine given to my mother.

No hurry but in due course I would like to know if the enquiries have come to a full stop i.e. finished. I rather fancy that they have which is a shame really because it allows the War Memorial hospital to continue as it has been doing with regards to how it treats the elderly patients under their care.

The sad thing is the War Memorial is basically a very good hospital but like everything else in life there is always a rotten apple in the barrel, sometimes two or three and I think they have or had a couple themselves.

Thanks for taking the trouble to look through the enclosed copies, most appreciated.

Yours sincerely,

Code A

M.E.Wilson (mr)

Phone Number Code A

In reply please quote FPD/2000/2047

21February 2002

Mr M E Wilson

Code A

GENERAL MEDICAL COUNCIL

Protecting patients, guiding doctors

Dear Mr Wilson

Thank you for your letter dated 14 February 2002. Your correspondence is being considered and we shall write again as soon as possible.

Your case has been allocated the following reference number **2000/2047.** It would be very helpful if you could quote this reference number whenever you write or speak to us.

If you have any questions please contact me or the officer in charge of this case, who is, Code A

Yours Sincerely

Code A

178 Great Portland Street London W1W 5JE Telephone 020 7580 7642 Fax 020 7915 3641
email gmc@gmc-uk.org www.gmc-uk.org

Code A

21/Feb/02

Dear Code A

I trust by now that you have received my package containing letters and other documents pertaining to my complaint against the Portsmouth N.H.S.Trust.

Anyway the reason for writing to you again is that a little problem has come up that I somehow overlooked when I was first preparing everything that I have sent you.

It concerns the enclosed photo copy of a page from my mother's medical notes and the part that worries me I have circled in red because I would very much like to know whether or not the War Memorial or any other hospital for that matter can discontinue giving someone what little life support a patient was receiving (in my mother's case a subcutaneous drip) without first discussing/consulting with the relatives.

I would have thought they had to before taking such action because it was inevitable what was going happen once they had removed the drip. My mother would die, what else.

The question is though were they within their legals rights to do this. That is what I have been trying, without any success, to find out.

It also seems very odd to me that they should discontinue giving my mother fluids even if it only was subcutaneously the day after I last visited my mother.

This Friday, the 22nd February a meeting is being held at the Fratton Police Station in Portsmouth between a Detective Superintendent James and a number of people whose cases/complaints which have centred on the War Memorial Hospital. They are going to be told why there will be no further enquiries and why no action has been taken with respect to their individual complaints.

So far as I know though the police never conducted any kind of enquiry with respect to my complaint. No matter the police have stressed in a letter which I received from them that they will not be looking into anymore individual cases.

Once again I thank you for taking the time to read what I have sent you.

Yours faithfully,

Code A

M.E.Wilson (mr)

HAMPSHIRE Constabulary

Paul R. Kernaghan QPM LL.B MA DPM MCIPD
Chief Constable

Major Incident Complex
Kingston Crescent
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Portsmouth
PO2 8BU

Our Ref. : MIC/Det.Supt/JJ/DM

Your Ref. :

Tel. : 0845 045 45 45
Direct Dial : Code A
Fax. : 02392 891884

13 February 2002

Mr M E Wilson

Code A

Dear Code A

I am writing following your previous communications with us, the last being on the 25th January 2002, concerning the circumstances of your mother, Edna PUMMELL's death after being admitted to Gosport War Memorial Hospital.

I am sorry that it has taken so long to advise you of the outcome of our enquiries. I am sure you will appreciate that the issues to consider were not straightforward.

You were amongst a number of people who contacted us to express concerns about patient care at Gosport War Memorial Hospital. In response to those complaints we conducted preliminary enquiries to establish whether or not there were grounds to investigate further. In the course of those enquiries we commissioned two medical experts reports to assist us.

After very careful consideration I have decided that we will not be conducting any further enquiries into patient deaths at Gosport War Memorial Hospital at this time. I have, however, forwarded the reports we commissioned to:

The General Medical Council
The United Kingdom Central Council for Nursing, Midwifery and Health Visiting
The Commission for Health Improvement
Portsmouth Healthcare NHS Trust
Isle of Wight Portsmouth and South East Hampshire Health Authority

HAMPSHIRE Constabulary

These are all bodies that have a regulatory or investigatory responsibility who can initiate further enquiries or act upon the reports as they deem appropriate.

I appreciate that you may be disappointed to be informed that the police are not undertaking further investigations. There are a range of reasons rather than one single reason that led me to the decision I outlined.

I thought that you may want to have the opportunity to speak to me personally about the decision. I intend to invite other concerned parties to a meeting so that I can explain our position.

I have arranged two alternative dates for you to attend Fratton Police Station.

Wednesday 20th February at 6pm
Friday 22nd February at 6pm

Please contact Code A on the number on the letterhead to indicate if either of these dates are convenient for you. If they are not we will make arrangements for another date.

I would urge you to make an arrangement to see me so that I can provide you with the fullest possible information arising from our enquiries.

Yours sincerely

Code A

J JAMES
Detective Superintendent

Code A,

15th.June 2002

Dear Code A,

I have photo copied all of the War Memorial Hospital records pertaining to my mother that I possess and trust that they will be of some help.

I have enclosed a copy of a letter dated 24th.June 1999, you might already have it and although it is not particularly relevant to what you asked me to send you I would nevertheless appreciate it if you would spare the time to read it because it does show how difficult it is for an individual, such as myself, to obtain the truth.

If you would care to look at Page 6 of Section 1 that I have enclosed and note especially that which I have underlined in red, then compare what a Dr.Lord said on that day (SixthNov.98) with what I have underlined in red on page 2 of the letter mentioned in above paragraph and signed by a Max Millett.

You will see that Dr.Lord talks about a month of gentle rehabilitation prior to moving on to a nursing home and yet according to Max Millett my mother was just about at death's door when she arrived at the War Memorial hospital. This only five days later on the 11th.Nov.98.

I do not remember if I sent you a copy of the Ombudsman's report, but I have enclosed three pages from it and here again is another example of what I have said above about trying to ascertain the truth. Impossible that is the only word for it.

On Page 4 Section 10 I have underlined once again in red the part about my mother having bed sores before being transferred from Haslar hospital to the War Memorial. Then on Page 7 Section 19 I have used my red pen to show the relevant lines that emphasis that my mother already had bed sores before she was admitted to the second hospital, the War Memorial.

Yet on Page 9 continuation of Section 21 which I have again underlined it states AFTER her transfer to the second hospital she developed pressures sores. An excuse perhaps for administrating the morphine but whether it was or not please could someone explain to me why they said AFTER when the medical records show it was before.

I will leave it at that but the whole of the investigation into my mother's death is a mass on contradictions and inaccuracies. Now one can begin to understand why on the 17th.Nov.98 I lost my temper big time (it is in my mother's medical notes) because the fobbing had even begun before that day.

In closing thanks for reading my letter and I trust the copies of the medical notes will be of some use.

Yours sincerely,

Code A

M.E.Wilson. (mr)

P.S.

THE ATTACHED PAGES FROM A DR REID & A MR MAX MILLETT ARE TO DO WITH WHY I CANNOT SEND YOU A COMPLETE SET OF MY MOTHER'S MEDICAL RECORDS.

PORTSMOUTH
HealthCare
NHS
TRUST

Mr. M. E. Wilson,
81 Gorseland Way,
GOSPORT.
PO13 0DG

Our ref
MM/LH/YJM
Your ref

Date
19th March, 1999
Ext
Code A

Dear Mr. Wilson,

Thank you for your letter dated 17th March, 1999. I am sorry you feel we are not taking you seriously. As I said in my last letter, Code A will be contacting you directly with regard to the issue of pain relief and medical records. I am sorry if my use of the term documentation caused confusion.

I understand that a letter from Code A to you will be in the post today. This will contain a copy of your mother's drug chart. In this letter Dr. Reid will also be offering to meet you again to discuss the drug chart and the medical records if you wish. To accept this offer you should telephone his secretary on Code A

Yours sincerely,

Code A

Max Millett
Chief Executive

To the attention of Code A
Please refer to the post script in my letter to you.

I did follow up Code A's offer, but due to us both having prior commitments then the earliest we could have met was in May. Please see copy of page 2 of his letter and my remarks as to what happened after this.

PORTSMOUTH HEALTHCARE NHS TRUST CENTRAL OFFICE

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

These doses of Morphine did not relieve Code A 's pain and subsequently the dose was increased to 10 mg (5 mls) which is well within the recommended normal range.

I do hope that this information relieves your concerns.*

Yours sincerely

Code A

DR R T REID, FRCP
MEDICAL DIRECTOR -
Portsmouth Healthcare NHS Trust

* If you would like to meet me to show you your mother's actual records, I would be very pleased to do so. Please give my secretary at Queen Alexandra Hospital a ring (Tel: Code A to arrange a time. I shall be on holiday from 29th March - 5th April, but I'd be happy to meet you from 6th April onwards.

PLEASE REFER TO THE POSTSCRIPT IN MY LETTER TO YOU.

No actual date was ever fixed for this meeting and instead I received the medical records that I have now forwarded copies of to you, which means that sometime between Dr.Reid"s letter and the meeting between us that never was, the remainder of my mother"s medical notes were destroyed.
Now wouldn"t one have expected that they would have taken extra care of Code A "s medical records, especially as my complaint against the Portsmouth H.C.T. was in full swing having already attended one meeting and another was to be held in either June or July. Convenient for them wasn't it, because said meeting never transpired and I had to laboriously continue on my own way towards the Ombudsman.

SECTION 1 PAGE 1

PORTSMOUTH HOSPITALS NHS TRUST

Infection Control Services
Exton 5
St Mary's Hospital
Milton Road
PORTSMOUTH
Hants P03 6AD
Tel: (01705) 286000 Ex Code A
Fax: (01705) 286000 Ex

ja/mvh/gwmhlet.ep

19 November 1998

Person-In-Charge
Dryad Ward
Gosport War Memorial Hospital
Bury Road
GOSPORT
Hants

Dear Colleague

Re: Edna PURNELL, Code A

Could you please stick the attached label on to the front cover of the above patient's notes.

Thank you for your help.

Yours sincerely

Code A

Infection Control Services

Code A

Code A

Code A

Code A

Code A