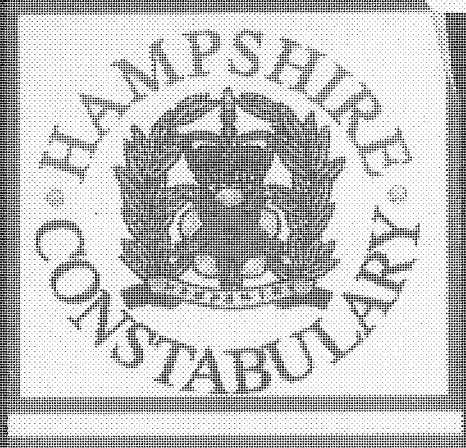
FFW 1/26/04




OPERATION
ROCHESTER

CONVOY NEAR
MEMORIAL
HOSPITAL

WITNESS
STATEMENTS
NEEDED

CLEARING
RICHARDS

61

**GMC AND DR. BARTON INDEX TO FILE 61**

**STATEMENTS OF WITNESSES OBTAINED BY THE POLICE:**

1. L. F. Black dated 31 January 2000
2. L. F. Richards (Black) dated 11 August 2004 **[copy of this statement not in Files 56 or 57]**
3. G. MacKenzie dated 6 March 2000
4. G. MacKenzie dated 27 April 1999 **[not in Files 56 or 57]**
5. A. Funnell - Medical Records Manager dated 25 February 2000
6. L. Humphrey - Quality Manager, Portsmouth NHS Trust dated 27 January 2000
7. L. Humphrey dated 26 May 2000
8. R. Giffin - Staff Nurse dated 6 June 2000
9. I. Reid - Consultant dated 7 June 2000 **[copy statement not in Files 56 or 57]**
10. P. Warren - Ambulance Man dated 24 May 2000 **[not in Files 56 or 57]**
11. M. Tanner - Assistant Ambulance Man dated 28 June 2000 **[not in Files 56 or 57]**
12. M. Edmondson - Nursing Officer dated 7 July 2000 **[copy not in Files 56 or 57]**
13. M. Berry - Health Care Support Worker dated 2 August 2000 **[not in Files 56 or 57]**
14. W. Edgar - Health Care Support Worker dated July 2000 **[not in Files 56 or 57]**
15. G. McCarthy - Health Care Support Worker dated 7 August 2000
16. Minh Ruston - Health Care Support Worker dated July 2000
17. K. Wilde - Health Care Support Worker dated 31 July 2000
18. J. Chappell - Staff Nurse dated 17 July 2003 **[not in Files 56/57]**
19. J. Rix - Medical Records dated 11 August 2004 **[not in Files 56/57]**
20. Dr. Black - Statement/Report dated 24 July 2005 **[not in Files 56/57, but note that despite the different date, this report seems to be the same as the report by the same author dated 17 May 2005 in the Clinical Team Assessment File]**
21. Dr. Black - Report dated 10 August 2005 **[not in Files 56 or 57, but note this report appears to be the same as other reports prepared by the same expert, but with a different date. See, for example, item 20 above]**

22. Dr. Black - Report dated 14 June 2005, 17 May 2005 **[not in Files 56/57, but appears to be a copy of the same report as in Items 20 and 21 above]**

RESTRICTED



# WITNESS STATEMENT

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

Statement of: LACK, LESLEY FRANCES

Age if under 18: OVER 18 (if over 18 insert 'over 18') Occupation: RETIRED

This statement (consisting of 20 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 anything which I know to be false or do not believe to be true.

Signed: Lesley Lack Date: 31/01/2008

I am the natural daughter of Gladys Mable RICHARDS (Nee BEECH ) who was born on the 13th April 1907 (13/04/1907).

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 John PERKINS - 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 Lesley HUMPHREY 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 Lesley HUMPHREY, 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 Lesley HUMPHREY, 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 Mrs Sue HUTCHINGS 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 Mrs HUMPHREY 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 Lesley HUMPHREY 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 the 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.

Signed: Lesley Lack Signature Witnessed by: R J BURT

2004(1)

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.

Signed: Lesley Lack Signature Witnessed by: R J BURT

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.

Signed: Lesley Lack Signature Witnessed by: R J BURT

2004(1)

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).

Signed: Lesley Lack Signature Witnessed by: R J BURT
2004(1)

RESTRICTED



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



RESTRICTED

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.

RESTRICTED



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 Broncho-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.

Signed: Lesley Lack Signature Witnessed by: R J BURT

2004(1)

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

RESTRICTED



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



RESTRICTED

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
2004(1)

RESTRICTED

Form MG11(T)



# WITNESS STATEMENT

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

Statement of: RICHARDS, LESLEY FRANCES

Age if under 18: O.18 (if over 18 insert 'over 18') Occupation: RETIRED REGISTERED GENERAL

This statement (consisting of 4 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 anything which I know to be false or do not believe to be true.

Signed: Lesley RICHARDS Date: 11/08/2004

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 21st August 1998 (21/08/1998) my mother 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 the daughter 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 my 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 my mother's death certificate with DCI BURT when I made my original statement.

Taken by: K M ROBINSON
Signed: Lesley RICHARDS Signature Witnessed by:
2004(1)

RESTRICTED

Continuation of Statement of: RICHARDS, LESLEY FRANCES



Signed: Lesley RICHARDS

Signature Witnessed by:

2004(1)

RESTRICTED

RESTRICTED



# WITNESS STATEMENT

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

Statement of: MACKENZIE, GILLIAN

Age if under 18: OVER 18 (if over 18 insert 'over 18') Occupation: RETIRED PERSONNEL MANAGER

This statement (consisting of 27 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 anything which I know to be false or do not believe to be true.

Signed: Gillian MacKENZIE Date: 06/03/2000

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 (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 Dr BASSETT who was my mother's GP. I asked

him about the choice of drugs which were being prescribed for my mother.

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

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

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

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

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

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

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

I would like to clearly state, at the outset, that I have absolutely no criticism whatsoever of the Royal Hospital Haslar . The staff, at this hospital, handled my mother's case in a very professional way both medically and so far as the quality of nursing was concerned.

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

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

progress.

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

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

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

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

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

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

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

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

On arrival I discovered that, in fact, my mother's new hip, which had been dislocated again at the Gosport War Memorial Hospital, had been manipulated back into place. She remained at

Haslar Hospital for two or three days and she was then transferred back to the Gosport War Memorial Hospital.

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

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

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

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

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

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

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

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

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

Once again I expressed the view that my mother was obviously in pain and I asked a care

assistant to go and get a qualified nurse.

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

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

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

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

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

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

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

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

through the door to x-ray department, throughout the time she was having the x-ray taken.

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

In the meantime my sister made enquiries at the Haslar Hospital in order to establish whether our mother could, once again, be transferred there. Whilst she was doing this I sat with my mother.

Around this time Philip BEED came into my mother's room. He told me that I would be reassured to know that my mother has not dislocated her hip again, 'but she may have suffered some bruising'.

Later, after my sister had returned, Philip returned to our mother's room where we sitting with her. He said, 'I'm going to make her life easier and give her an injection of Diamorphine'.

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.

RESTRICTED



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.

Signed: Gillian MacKENZIE Signature Witnessed by:

2004(1)

RESTRICTED

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

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

In my view a consultant's opinion should have been sought when the haematoma was discovered. It is also my view that Dr BARTON's decision not to refer our mother back to Haslar Hospital where the causes of her condition, and not merely the symptoms, could have been addressed, effectively denied her the opportunity of having a chance to be treated, to survive and to recover even if this was for a short time. I believe that a decision was made, for reasons which I do not accept, to reject treatment options which would have given our mother a chance to recover and, instead, a course of palliative treatment was commenced, which effectively, condemned her to death without any chance of recovery. Palliative treatment does not necessarily have to cause unconsciousness.

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

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

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

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

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

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

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

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

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

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

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

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

I have to say that I have serious concerns about the possible and inappropriate use of

'Oramorph', at this stage in my mother's treatment, as a means of suppressing the 'inconvenient' aspects of her anxiety and dementia.

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

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

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

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

In due course, following my mother's death, I received a copy of the Portsmouth Health Care Trust's response to the copy of my sister's notes (LFL/2) which had been given to Mrs HUMPHREY on the 19th August 1998 (19/08/1998).

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

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

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

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

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

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

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

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

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

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

In the Health Record (LH/1/C), to which I will refer in greater detail later in my statement, the time of my mother's fall is confirmed as being 1330 and the venue is given as her room. However, my niece, Mrs REED, had apparently seen her, as I understood it, in the patient's sitting room but I may be wrong. If my mother had been in the patient's sitting room, by herself, this was neglectful because the staff knew she would attempt to get out of her chair if she wanted to use the toilet and she couldn't possibly do it by herself (see AF/1/C/21).

By further reference to the letter of response (LFL/3) I noted that in reply to the question, 'Who attended her?'. There is a response, 'She was attended by a staff nurse 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 ' Riek 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?'

# Code A

# Code A

# Code A

# Code A

# Code A

# Code A

# Court Print Index

# Court Print Index

| Name | Occupation | Doc ID | Page Numbers |
|---|---|---|---|
| LACK, LESLEY FRANCES | RETIRED | S3 | 1- 21 |
| MACKENZIE, GILLIAN | RETIRED PERSONNEL MANAGER | S4 | 26- 45 |
| MACKENZIE, GILLIAN M | | S4A | 46- 51 |
| RICHARDS, LESLEY FRANCES | RETIRED REGISTERED GENERAL NURSE | S3A | 22- 25 |

# Code A

# Code A

# Code A

# Code A

# Code A

# Code A

# Code A

# Code A

# Code A

# Code A

# Code A

# Code A

# Code A

# Code A

# Code A

# Code A

# Code A

# Code A

# Code A

# Code A

# Code A

# Code A

# Code A

# Code A

# Code A

# Code A

# Code A

# Code A

# Code A

# Code A

# Code A

# Code A

# Code A

# Code A

# Code A

# Code A

# Code A

# Code A

# Code A

# Code A

# Code A

# Code A

# Code A

# Code A

# Code A

# Code A

# Code A

# Code A

# Code A

# Code A

# Code A

# Code A

# Code A

# Code A

# Code A

# Code A

# Code A

# Code A

# Code A

# Code A

# Code A

# Code A

# Code A

# Code A

# Code A

# Code A

# Code A

# Code A

# Code A

# Code A

# Code A

# Code A

# Code A

5829

Gladys Richards Daughter Statements 14 June 2005

## CONTENTS

1. **INSTRUCTIONS**

To examine and comment upon the statements of Mrs Gladys Richards daughters. In particular, if they raise issues that would impact upon any expert witness report prepared.

2. **DOCUMENTATION**

This report is based on the following document:

2.1 Witness statement of Gillian Mackenzie, Lesley Frances Luck, Gillian McKenzie on Lesley Richards as provided to me by the Hampshire Constabulary (May 2005). Also note extracts and commentary (Gillian McKenzie) June 2005.

2.2 Report regarding Gladys Richards (BJC/41) Dr D Black 2005.

3. **COMMENTS**

**3.1 Comments on Witness Statement (2.1)**

3.1.1 I have read all the statements and the only new significant findings appear to have been that staff have suggested that "a haematoma" was the cause of her deterioration and pain on return from Haslar for the second time on the 17th August. There is no mention of this that I have been able to find in the medical notes.

4. **CONCLUSION**

4.1 Having read all the documents above provided by Hampshire Constabulary, I would not wish to make any changes to my expert statement.

Code A

18/6/05

## SUMMARY OF CONCLUSIONS

Gladys Richards presents an example of a common, complex problem in geriatric medicine. A patient with one major progressive and end stage pathology (a dementing illness) develops a second pathology, has surgery, has a complication after that surgery, has more surgery and gradually deteriorates and dies.

In my view a major problem in assessing this case is poor documentation in Gosport Hospital in both the medical and nursing notes, making a retrospective assessment of her progress difficult. Good Medical Practice (GMC 2001 states that "Good clinical care must include an adequate assessment of the patient's condition, based on the history and symptoms and if necessary an appropriate examination"....."in providing care you must keep clear, accurate, legible and contemporaneous patient records which report the relevant clinical findings, the decisions made, the information given to patients and any drugs or other treatments prescribed". "Good clinical case must include – taking suitable and prompt action when necessary".... "Referring the patient to another practitioner when indicated"...."in providing care you must – recognise and work within the limits of your professional competence"..."prescribe drugs and treatments, including repeat prescriptions only where you have adequate knowledge of the patients health and medical needs". The lack of detail in the medical notes, the absence of evidence of asking for advice on 17th August and the lack of recording why decisions were made or if the patient was properly examined present poor clinical practice to the standards set by the General Medical Council. In particular, I am concerned the anticipatory prescription of Opioid analgesia on her admission to Gosport War Memorial Hospital. If no justification for this can be identified or proven, then I believe that this was negligent practice and may have contributed to her fall on the ward. I also believe that the dose of Diamorphine, in particular prescribed on the 17th August, was sub optimally high. However I do not believe this contributed in any significant way to Mrs Richards death and that her death was by natural causes.

## 1. INSTRUCTIONS

To examine the medical records and comment upon the standard of care afforded to the patient in the days leading up to her death against the acceptable standard of the day. Where appropriate, if the care is felt to be sub-optimal, comment upon the extent to which it may or may not disclose criminally culpable actions on the part of individuals or groups.

## 2. ISSUES

2.1. Was the standard of care afforded to this patient in the days leading up to her death in keeping with the acceptable standard of the day.

2.2. If the care is found to be suboptimal what treatment should normally have been proffered in this case.

2.3. If the care is found to be suboptimal to what extent may it disclose criminally culpable actions on the part of individuals or groups.

## 3. CURRICULUM VITAE

**Code A**

Code A

**PRESENT POST**

Code A

**PREVIOUS POSTS**

Code A

Code A

**PUBLICATIONS**

Code A

# Code A

# Code A

# Code A

# Code A

BOOK

## Code A

RECENT SIGNIFICANT PRESENTATIONS

# Code A

# Code A

## 4. DOCUMENTATION

This Report is based on the following documents:

[1] Full paper set of medical records of Gladys Richards (BJC/41)

[2] Operation Rochester Briefing Document Criminal Investigation Summary.

[3] Hampshire Constabulary Operation Rochester Guidance for Medical Experts.

[4] Commission for Health Improvement Investigation Report on Portsmouth Health Care NHS Trust at Gosport War Memorial Hospital (July 2002).

[5] Palliative Care Handbook Guidelines on Clinical Management, Third Edition, Salisbury Palliative Care Services (1995); Also referred to as the 'Wessex Protocols.'

## 5 CHRONOLOGY/CASE ABSTRACT. (The numbers in brackets refer to the page of evidence, the numbers with 'H' in front are the Haslar notes).

5.1. Gladys Richards was a 91 year old lady and in 1998 was admitted as an emergency on 29th July 1998 to the Haslar Hospital (H39).

5.2. She had had a progressive dementing illness documented as short term memory loss in 1998 (435), a mental test score of 4/10 in 1994 (443) and a mental test score of 0/10 in 1996 (451). She was admitted to the Glen Heathers Nursing Home in 1994 (202) and was moderately dependent with a Barthel of 11/20 at that time (200). She was seen by a psycho-geriatrician, Dr Banks, who in 1998 found that

she had end stage dementia (473). The nursing home noticed that she was wandering and very frail in July 1998 (563). The nursing home notes document multiple falls.

5.3. On admission to the Haslar Hospital, a fractured neck of femur is diagnosed and she is treated with a right hemi-arthroplasty (H50). Recovery seems uncomplicated, though it is complicated by agitation. She is seen by Dr Reed on 3rd August (23) who notes her long standing dementia. He finds her pleasant, co-operative, with little discomfort on passive movement and she should be transferred to the Gosport War Memorial hospital to see if it was possible to remobilise her (466,467).

5.4. Her drug charts in Haslar Hospital show that no regular pain killer is given during her first admission (H110), although Diclofenac was prescribed but not given. She does receive intravenous morphine 2.5. mgs on 31st July, then single doses on the 1st and 2nd August (H114). She then receives regular Co-codamol orally, although it is written up Prn, until 7th August. After this date t there appears to be no further painkillers given.

5.5. The nursing cardex in Haslar (H152, H167) does not mention any pain during her recovery.

5.6. She is discharged to the Gosport War Memorial Hospital on 11th August and seen by Dr Barton who notices her previous hysterectomy in 1953, her cataract operations, thats he is deaf and that she has "Alzheimer's Disease". She notes on examination that her impression is of a frail demented lady who is not obviously in pain. It is not clear if a general examination has been undertaken. She mentions that her Barthel score is 2 (heavily dependent), she transfers with a hoist. She also states "I am happy for nursing staff to confirm death".

5.7. The next medical note in on 14th August and states that sedation/pain relief has been a problem, screaming not controlled by Haloperidol and very sensitive to Oramorphine. Fell out of chair last night, right hip shortened and internally rotated, daughter aware and not happy. Is this lady well enough for another surgical procedure? She has an x-ray that notes the hip is dislocated and is transferred back to the Haslar Hospital.

5.8. The nursing notes for this first admission state that she had a Barthel of 3/20 on admission (40). Is highly dependent with a Waterlow score of 27 (41). The nursing care plan for the 12th (49) mentions that Haloperidol was given because she woke from sleep very agitated. It mentions that on the 13th August Oramorphine is given at 21.00 (50). It mentions an x-ray needed the following morning. On 14th August pain is mentioned in the right leg in the nursing cardex (50). I find no other mention of pain in the nursing cardex.

5.9. Oramorphine 10 mgs in 5mls (62) is written up prn on admission to Gosport Hospital, two doses are given on 11th August, one dose 12th August, one dose 13th August in the evening (as confirmed in the nursing cardex) and one dose on 14th August in the morning (as confirmed in the nursing cardex). Also on the prn side of the drug cardex on admission to Gospor tis prescribed Diamorphine 20 – 200 mgs subcutaneously, August, Hyoscine 200 – 800 mgs subcutaneously in 24 hours, both written up on 11th August. Midazolam 20 – 80 mgs subcut in 24 hours in written up on the 18th August. None of these drugs are prescribed until her subsequent return from Haslar.

5.10. On 14th August she is transferred to Haslar where a dislocation of a hip is confirmed by x-ray (H67) and is reduced under sedation (H67). She has an uneventful recovery and is transferred back to Gosport War Memorial on 17th August. Discharge summary mentioning Haloperidol, Lactulose, Co-codamol and Oramorphine 2.5 – 5mgs for pain (H79), although the Oramorphine was never given in Haslar.

5.11. Dr Barton writes in the notes on the 17th August after her re-admission to continue Haloperidol and only give Oramorphine if in severe pain, and that she wishes to see the daughter again. The nursing cardex 17th August says patient very distressed and appears to be in pain (45). In the afternoon of 17th August, states, "in pain and distress, agree with daughter to give her mother Oramorphine 2.5 mgs in 5 mls". Due to the pain, a further x-ray is ordered and no dislocation is seen (46) (75).

5.12. On 18th August, Dr Barton notes the patient is still in great pain, nursing is a problem, she suggests subcutaneous Diamorphine, Haloperidol and Midazolam and that she will see the daughters. The nursing cardex records the decision to pain control by syringe driver (46). She then receives Diamorphine 40 mgs daily in a syringe driver, with Haloperidol 5 mgs and 20 mgs Midazolam until her death

on 21st August 1998.

5.13. An unusual feature of the original Gosport War Memorial Drug Chart (64) is that Oramorphine 2.5 mgs 4 hourly was written up on the regular prescription side on the 11th August, together with 5 mgs at night regularly. It then has the letters prn against both of these prescriptions which presumably refers the prescriber back to the actual prescriptions which were given on a prn basis of Oramorphine (62).

## 6. TECHNICAL BACKGROUND / EXAMINATION OF THE FACTS IN ISSUE

6.1. This section will consider whether there were any actions so serious that they might amount to gross negligence or any unlawful acts, or deliberate unlawful killing in the care of Elsie Lavender. Also whether there were any actions or admissions by the medical team, nursing staff or attendant GP's that contributed to the demise of Mrs Lavender, in particular, whether beyond reasonable doubt, the actions or omissions more than minimally, negligibly or trivially contributed to death.

6.2. Mrs Richards was suffering from the terminal stage of a dementing process, probably Alzheimer's disease. This is reflected in the comments earlier in 1998 by a consultant psycho-geriatrician that she had end stage disease and the well-documented progression of this over many years. Despite this though, she was still able to get around in the nursing home and as is often the case, even with the best forms of monitoring, having multiple falls.

6.3. As a result of one of these, she suffers a fractured neck of femur. Sadly this is very common, it is also common for the original fall to lead to a partial fracture which is not diagnosed and then only subsequently sometimes hours, sometimes days later, does it become a clinically obvious fractured neck of femur. Patients with dementia and fractured neck of femur are often missed in hospitals as well as in nursing homes, even by the most astute of staff.

6.4. She has a successful hemi-arthroplasty in Haslar, receives pain relief but does not need any pain relief for the 3 days on 7th – 10th August. She remains highly dependent though with a Barthel of 3/10. Although she is described as weight bearing in Haslar, the Barthel describes no mobility at all as does the fact that a hoist is needed for transfer at Gosport War Memorial. It is a fact that many patients with dementia, never walk again after a fractured

neck of femur and indeed the mortality rate in the months after a fractured neck of femur is extremely high, particularly in the very elderly and those with mental impairment.

6.5. However, she survived the first operation and is seen by Dr Reed, Consultant Geriatrician who believes that she should be transferred to Gosport War Memorial to see if any mobility can be regained. This is not unreasonable; it may make her new placement in a nursing home easier if she is able to have some increase in independence.

6.6. When she is transferred to Gosport War Memorial Hospital she is seen by Dr Barton who fails to record a clinical examination apart from a general statement she is a frail and demented lady. However, she does state she is not obviously in pain. Despite this, she has written up her drug charts for both low dose of Oramorphine and a high dose of Diamorphine. I can find no clinical justification at all for this in the notes. If she was worried about pain and feared that it would be hard for the nursing staff to get hold of the doctor, then it would be reasonable to write up a prn of a mild pain killer such as Paracetamol and then possibly a small dose of an Opioid if ordinary analgesia did not work. Dr Barton also writes up on the regular prescription side a significant dose of Oramorphine, although this has prn put next to it. I believe this to be highly sub-optimal prescribing.

6.7. Oramorph is actually given by the nursing staff on 11th, 12th and 13th, certainly prior to the definite diagnosis of the dislocation. I can find no justification for giving the drugs in the medical or nursing notes. The comment on the 14th August that pain relief has been a problem, could be relating to since the dislocation. If no reason can be documented or proven, then this is certainly sub-optimal drug prescribing and management. Indeed to prescribe a controlled drug without a clinical indication must be considered negligent in my view.

6.8. She is identified as having had dislocation of hip on 14th August. This probably resulted from the documented fall and is not uncommon in frail older people after a fractured neck of femur repair. The Diamorphine that had been given might have contributed in part to this, though she was also on major tranquillisers and suffering from severe dementia. All of which makes such an outcome quite likely.

6.9. She then returns to Haslar Hospital, the dislocation is reduced under local sedation, which heavily sedates her, and she is then returned back to Gosport War Memorial. She is never right from

the moment she returns. She is now documented to be in significant pain. No cause for this pain is suggested in the notes. In my view it would have been appropriate for Dr Barton to discuss Mrs Richards with the surgical team at Haslar Hospital, or with her consultant, to decide if anything further should be done at this stage. Unfortunately, not only is the mortality high after a single operation in a patient with end stage dementia but having a further operation is often an agonal event. It is also unexplained what was causing her pain. It seems to me that it would be not unreasonable at this stage to provide palliative care and pain relief. Diamorphine is specifically prescribed for pain and is commonly used for pain in terminal care. Diamorphine is compatible with Midazolam and can be mixed in the same syringe driver. Diamorphine subcutaneously after oral morhine, is usually given at a maximum rate of 1 – 2 (i.e. up to 10 mgs Diamorphine in 20 mgs of Oramorphine). The maximum amount of Oramorphine she had received in 24 hours was 20 mgs prior to starting the infusion pump. Thus as her pain was not controlled, it would be appropriate to give a higher dose of Diamorphine and in convention this would be 50% greater than the previous days (Wessex Guideline) but some people might give up to 100%. A starting dose of Diamorphine of 10 – 20 mgs in 24 hours would seem appropriate. Mrs Richards was actually prescribed 40 mgs, which in my view was unnecessarily high.

6.10. Midazolam is widely used subcutaneously in doses from 5 – 80 mgs for 24 hours and is particularly used for terminal restlessness. The dose of Midazolam used was 20 mgs for 24 hours which is within current guidance, although many believe that elderly patients may need a lower dose of 5 – 20 mgs per 24 hours (Palliative Care. Chapter 23 in Brocklehurst's Text Book of Geriatric Medicine 6th Edition 2003).

6.11. It was documented that Mrs Richards is peaceful on this dose in the syringe driver and a rattly chest is documented in the medical notes on 21st prior to her death (30).

6.12. I understand the post mortem and the cause of death said:
1a Bronchopneumonia.
In my view the correct Death Certificate would have said:
1a Fractured Neck of Femur
2 Severe dementia.
There is no doubt that after people have been dying over a number of days, if a post mortem is performed, then secretions and changes of Bronchopneumonia are often found in the lungs as the very final agonal event. This allows clinicians to put the phrase "Bronchopneumonia" on the death certificate.

Unfortunately, under current guidance to Coroners if 'fractured neck of femur' is written on the death certificate, then the Coroner has little option but to perform a post mortem as the death is deemed to be non accidental. Where patients have not died immediately after a fractured neck of femur, some Coroner's Officer's encourage clinicians to leave 'fractured neck of femur' off the death certificate to save the relatives the potential trauma of a post mortem. I believe this is poor national practice, but it is not a specific criticism in this case.

## 7. OPINION

7.1. Gladys Richards presents an example of a common, complex problem in geriatric medicine. A patient with one major progressive and end stage pathology (a dementing illness) develops a second pathology, has surgery, has a complication after that surgery, has more surgery and gradually deteriorates and dies.

7.2. In my view a major problem in assessing this case is poor documentation in Gosport Hospital in both the medical and nursing notes, making a retrospective assessment of her progress difficult. Good Medical Practice (GMC 2001 states that "Good clinical care must include an adequate assessment of the patient's condition, based on the history and symptoms and if necessary an appropriate examination"....."in providing care you must keep clear, accurate, legible and contemporaneous patient records which report the relevant clinical findings, the decisions made, the information given to patients and any drugs or other treatments prescribed". "Good clinical case must include – taking suitable and prompt action when necessary".... "Referring the patient to another practitioner when indicated"...."in providing care you must – recognise and work within the limits of your professional competence"..."prescribe drugs and treatments, including repeat prescriptions only where you have adequate knowledge of the patients health and medical needs". The lack of detail in the medical notes, the absence of evidence of asking for advice on 17th August and the lack of recording why decisions were made or if the patient was properly examined present poor clinical practice to the standards set by the General Medical Council. In particular, I am concerned the anticipatory prescription of Opioid analgesia on her admission to Gosport War Memorial Hospital. If no justification for this can be identified or proven, then I believe that this was negligent practice and may have contributed to her fall on the ward. I also believe that the dose of Diamorphine, in particular, prescribed on the 17th August, was sub optimally high. However I do not believe this contributed in any significant way to Mrs Richards death and that her death was by natural causes.

## 8 LITERATURE/REFERENCES


1. Good Medical Practice, General Medical Council 2002
2. Withholding withdrawing life, prolonging treatments: Good Practice and decision making. General Medical Council 2002.
3. Palliative Care, Welsh J, Fallon M, Keeley PW. Brocklehurst Text Book of Geriatric Medicine, 6th Edition, 2003, Chapter 23 pages 257-270.
4. The treatment of Terminally Ill Geriatric Patients, Wilson JA, Lawson, PM, Smith RG. Palliative Medicine 1987; 1:149-153.
5. Accuracy of Prognosis, Estimates by 4 Palliative Care Teams: A Prospective Cohort Study. Higginson IJ, Costantini M. BMC Palliative Care 2002:1:129
6. The Palliative Care Handbook. Guidelines on Clinical Management, 3rd Edition. Salisbury Palliative Care Services, May 1995.


## 9. EXPERTS' DECLARATION

1. I understand that my overriding duty is to the court, both in preparing reports and in giving oral evidence. I have complied and will continue to comply with that duty.
2. I have set out in my report what I understand from those instructing me to be the questions in respect of which my opinion as an expert are required.
3. I have done my best, in preparing this report, to be accurate and complete. I have mentioned all matters, which I regard as relevant to the opinions I have expressed. All of the matters on which I have expressed an opinion lie within my field of expertise.
4. I have drawn to the attention of the court all matters, of which I am aware, which might adversely affect my opinion.
5. Wherever I have no personal knowledge, I have indicated the source of factual information.
6. I have not included anything in this report, which has been suggested to me by anyone, including the lawyers instructing me, without forming my own independent view of the matter.
7. Where, in my view, there is a range of reasonable opinion, I have indicated the extent of that range in the report.
8. At the time of signing the report I consider it to be complete and accurate. I will notify those instructing me if, for any reason, I subsequently consider that the report requires any correction or qualification.
9. I understand that this report will be the evidence that I will give under oath, subject to any correction or qualification I may make before swearing to its veracity.

10. I have attached to this report a statement setting out the substance of all facts and instructions given to me which are material to the opinions expressed in this report or upon which those opinions are based.

## 10. STATEMENT OF TRUTH

I confirm that insofar as the facts stated in my report are within my own knowledge I have made clear which they are and I believe them to be true, and the opinions I have expressed represent my true and complete professional opinion.

Signature: Code A Date: 16/5/05