Field Fisher Waterhouse

GENERAL MEDICAL COUNCIL

-and-

FFW/147/06.

DR BARTON

WITNESS STATEMENTS

Field Fisher Waterhouse

GENERAL MEDICAL COUNCIL

-and-

DR BARTON

WITNESS STATEMENTS

1 OF 4

General Medical Council

Dr Jane Barton

Statement of Lynda Marion Wiles

I, **Lynda Wiles**, will say as follows:

1. I am the daughter of Leslie Pittock.

2. Exhibited to this statement and marked **LW/1** is a copy of my witness statement dated 8 November 2004.

3. I can confirm that I have been given the opportunity to add to or amend this statement but do not wish to do so.

4. I understand that my statement may be used in evidence for the purposes of a hearing before the General Medical Council's Fitness to Practise Panel and for the purposes of any appeal, including any appeal by the Council for Healthcare Regulatory Excellence. I confirm that I am willing to attend the hearing to give evidence if asked to do so.

I believe that the facts stated in this witness statement are true

Signed: .....

Lynda Marion Wiles

Dated: .....

Code A

Code A

Code A

Code A

General Medical Council

Dr Jane Barton

Statement of Dr Michael Brigg

I, **Michael Brigg**, will say as follows:

1. I am a General Practitioner at Forton Medical Centre, Whites Place, Gosport and have held this position since October 1993.

2. Exhibited to this statement and marked **MB/1** is a copy of the witness statement dated 16 February 2005 I made in relation to the care of Leslie Pittock.

3. I can confirm that I have been given the opportunity to add to or amend this statement but do not wish to do so.

4. I understand that my statement may be used in evidence for the purposes of a hearing before the General Medical Council's Fitness to Practise Panel and for the purposes of any appeal, including any appeal by the Council for Healthcare Regulatory Excellence. I confirm that I am willing to attend the hearing to give evidence if asked to do so.

I believe that the facts stated in this witness statement are true

Signed: Code A

Dr Michael Brigg

Dated: 29/5/09

Code A

Code A

Code A

Code A

Code A

Code A

Code A

Code A

General Medical Council

Dr Jane Barton

Statement of Alan Lavender

I, **Alan Lavender**, will say as follows:

1. I am the son of Elsie Hester Lavender.

2. Exhibited to this statement and marked **AL/1** is a copy of the witness statement dated 19 May 2004 I made in relation to my mother's care.

3. I can confirm that I have been given the opportunity to add to or amend this statement and wish to state that in the second paragraph of page 1 that I moved to Warsash from Royston in 1990to be closer to my mother and then took early retirement in 1991.

4. I understand that my statement may be used in evidence for the purposes of a hearing before the General Medical Council's Fitness to Practise Panel and for the purposes of any appeal, including any appeal by the Council for Healthcare Regulatory Excellence. I confirm that I am willing to attend the hearing to give evidence if asked to do so.

I believe that the facts stated in this witness statement are true.

Signed: ..... Code A

Alan Lavender

Dated: .....24th March 2008

General Medical Council

Dr. Jane Barton

Exhibit AL1

This is the Exhibit marked "AL1" referred to in the statement of Alan Lavender:-

- Statement dated 19 May 2004 (regarding Elsie Lavender)

Code A

Code A

Code A

Code A

Draft
(14.08.2008)

General Medical Council

Dr Jane Barton

Statement of Marilyn Jackson

I, **Marilyn Jackson**, will say as follows:

1. I make this statement in relation to the treatment of my late mother, Alice Wilkie, at the Gosport War Memorial Hospital in August 1998.

2. My mother's date of birth was 2 September 1916 and she sadly passed away on 21 August 1998.

3. My mother was admitted to the Queen Alexandra Hospital on 31 July 1998. She was transferred to Gosport War Memorial Hospital on 6 April 1998 for assessment and rehabilitation.

4. As I was dissatisfied with the treatment that my mother received at Gosport War Memorial Hospital I complained the General Medical Council. Exhibited to this statement and marked "**MJ/1**" is a copy of my letter dated 11 April 2002 addressed to Mr Michael Hudspith of the General Medical Council.

5. My mother lived at the Addenbrooke Nursing Home. On 31 July 1998 she was transferred to the Queen Alexandra Hospital as a result of a urinary tract infection. My mother stayed at the Queen Alexandra Hospital for five days and appeared to be making good progress. Subsequently she was sent to the Gosport War Memorial Hospital for assessment and rehabilitation.

6. In exhibit "**MJ/1**" I detailed the treatment that my mother received at the Gosport War Memorial Hospital and my conversations with Philip Beed. My main concern about my mother's treatment was why she was placed on diamorphine via a syringe driver before any other drugs had been tried to relieve her discomfort.

7. On 21 August 1998 I met with Dr Barton. I found her to be very uncaring, rude and abrupt and she did not bother to explain to either myself or my daughters either who she was or what the current situation was regarding my mother. I felt that this was unacceptable and unprofessional on the part of Dr Barton.

8. Sadly my mother passed away on 21 August 1998.

9. Subsequent to my mother's death I received my mother's medical file and was unhappy with the contents. I detailed my concerns in my letter marked "**MJ/1**".

10. I contacted the police in April 2001 regarding my mother's care and my concerns. I was unhappy with the lack of investigation by the police. Exhibited to this letter and marked "**MJ/2**" is a copy of my letter dated 11 April 2002 to Chief Constable Paul R Kernaghan detailing my concerns.

11. Further exhibited to this statement and marked "**MJ/3**" are copies of correspondence that I received from the General Medical Council regarding my mother's case between 15 April 2002 and 11 July 2002.

12. I can confirm that I did not give an official witness statement to Hampshire Constabulary, however I was visited at my home address on 11 February 2004 by Detective Constable Robinson. Exhibited to this statement and marked "**MJ/4**" is a copy of his officer's report dated 29 April 2004.

13. [My concerns regarding the care of my mother are detailed accurately in this officer's report and I have nothing more to add]. *[Mrs Jackson, please let me know if this is the not the case. If you have any further comments that you wish to add to this statement I will be more than happy to include them. It is important that this statement accurately reflects your concerns].*

14. I understand that my statement may be used in evidence for the purposes of a hearing before the General Medical Council's Fitness to Practise Panel and for the purposes of any appeal, including any appeal by the Council for Healthcare Regulatory Excellence. I confirm that I am willing to attend the hearing to give evidence if asked to do so.

I believe that the facts stated in this witness statement are true

Signed: ... Code A

Marilyn Jackson

Dated: ....22.8.08.....

Code A

11 April 2002

General Medical Council
178 Great Portland Street
London
W1W 5JE

Mr Michael Hudspith

FORMAL COMPLAINT

I am writing further to our recent telephone conversation with yourself regarding my mother Alice Wilkie's treatment at the Gosport War Memorial Hospital in August 1998.

I am completely dissatisfied with the sub-standard care that my mother received and her subsequent death on 21 August 1998. To summarise briefly the events which took place, my mother was taken from Addenbrooke Nursing Home on 31 July 1998 to Queen Alexandra hospital as a result of a Urinary Tract Infection. My mother stayed at Queen Alexandra for five days and appeared to be making good progress. Subsequently, she was sent to the Gosport War Memorial Hospital for assessment and rehabilitation.

At the Gosport War Memorial my mother appeared increasingly sleepy, weak and unwell, she couldn't stand or walk unaided. When I queried this with the ward sister I was simply told "yes, she was deteriorating". I was given no explanation as to why or what actions were being taken to help her. Just a few days later, I was called into Phillip Beed's office and was advised that my mother was dying and there was nothing that the hospital could do to help her. I thought this was strange at the time and was at not point given any explanation as to why this deterioration had taken place and why nothing could be done. I told Phillip Beed that I did not wish for my mother to suffer but that was the depth of our conversation at this time. There was no explanation of what actions would be taken with my mother and her care.

Whilst visiting on August 20th I noticed that my mother appeared to be in pain. When I mentioned this to the nursing staff they were dismissive and said that they could see no evidence of this. I had to ask twice and waited for over an hour before Phillip Beed came to see me. He did not examine my mother at this stage and did nothing to ascertain the level of pain she was in, but he did say he would arrange for some pain relief that would make her sleepy. I left the hospital at 13.55 and at this point nothing had been done to alleviate my mothers discomfort despite the fact that her notes state that she was placed on a syringe driver at 13:50. I had not left the hospital at this time so where has this discrepancy come from? I telephoned my daughter as I was very concerned about my mother and asked her to go to the Gosport War Memorial to find

out what was happening. When my daughter arrived, the nurse said to her in a very rude manner "your mother seems to think that your grandmother is in pain". By the time I returned to the hospital at eight o'clock that evening, my mother had been placed on a syringe driver administering Diamorphine drugs into her system. She was totally unconscious and never regained it. She died the next evening.

I have many questions that have never been answered regarding this. Why was my mother placed on Diamorphine via a syringe driver, when only that afternoon, the nursing staff appeared unaware and unconcerned that she was in any pain? Why were other drugs not tried first to relieve her discomfort and why was the Diamorphine administered in 30mg quantities? I believe that 5 to 10 mg's would be a normal dosage. I cannot understand why Diamorphine was used when no other drugs had been tried first. Why was no investigation done to find out where my mothers pain was and the cause of it. I suggest that it could have been a simple problem that could have been resolved with less severe pain relief.

Also, early on the morning of the 21st August a Lady came to my mothers bedside and merely stated "anytime now" before walking away. I recognised the lady as Dr Barton. She was very uncaring, rude and abrupt and did not bother to explain to myself or my daughters either who she was or what the current situation was regarding my mother. This is unacceptable and unprofessional on the part of Dr Barton.

I was persuaded to go home for some food and a change of clothes late in the afternoon of the 21st. I expressed my concern about leaving her to Phillip Beed as I did not wish for her to be alone. I was assured by Beed that should any change take place he would contact us immediately. However, when I returned a short while later Phillip Beed entered my mothers room in front of us and told us that she had just died. However, I do not believe that she died upon our return, but I believe that she died alone and had not been monitored in our absence. Phillip Beed told us that my mother had waited until she heard our voices before passing away, however, it was quite obvious that she had died much earlier than this. My mothers records state that her daughter and granddaughter were present at time of death, this is disputed by us and we know this was not the case.

I have now received my mother's medical file and am most distressed by it. The file itself appears to be incomplete and the details contained within it are sadly lacking to say the least. One of my main concerns is that in this file, there is a note from Phillip Beed stating that I had agreed for my mother to be placed on a syringe driver. I can categorically tell you that this 'alleged' conversation never took place. Also, there appears to be a mix up on the records of my mother and another patient Mrs Gladys Richards. A note stating that my mother was given Oramorph was crossed out with a note saying that this was written in error on the wrong notes. Also, the time of death on my mothers files says 18:30 and 21:20. How can she die twice? After speaking with Gladys Richards daughter she has confirmed that 21:20 is the time her mother passed away. This is gross incompetence on the part of the hospital and I wonder whether my mother was given these drugs in error or whether it was only written on her notes in error. The notes themselves are incomplete and there are whole days when nothing is written on them and there is no record of what, if anything, she was given to eat or drink. I would expect that if she had a UTI, was catheterised and

dehydrated then there should be a note of both her intake and her urinary output. This was done at Queen Alexandra but does not appear to be done at the Gosport War Memorial.

I would also like to know why my mothers notes state DNR on them without this being discussed with myself and also why her place at Addenbrooke was given up without my knowledge. After all the note from Queen Alexandra said that she was merely entering the War Memorial for rehab and assessment, she did not go there to die!!!

I am not prepared to let this matter lie. I believe that my mother died as a direct result of negligence on the part of the hospital and the administering of Diamorphine drugs which were not necessary. The death certificate states she died of Pneumonia but she showed no symptoms of this before dying and we were at no point advised of this condition. I am not happy that this case is being left and am pursuing the matter with the Police further as I believe that criminal acts have taken place. I will not rest until appropriate action has been taken against Dr Barton and Phillip Beed.

I look forward to hearing from you soon.

Yours sincerely

Mrs M Jackson

PP. Code A

CC: Chief Constable Kernaghan – Hampshire Constabulary
Peter Viggers MP
David Blunkett MP
Iain Duncan Smith MP

Code A

11 April 2002

Chief Constable Paul R Kernaghan
Police Headquarters
West Hill
Romsey Road
WINCHESTER
Hampshire
SO22 5DB

FORMAL COMPLAINT

Dear Chief Constable Kernaghan

I am writing to make a full formal complaint against Detective Superintendent John James and the so called investigation which has 'taken' place regarding the Gosport War Memorial Hospital.

I contacted the Police in April 2001 regarding my mother Mrs Alice Wilkie and my concerns regarding her care and the administration of drugs during her stay in August 1998. I was advised by Detective Sergeant Dave Sackman that this would be investigated and he would advise further. I heard nothing from the Police until I telephoned a number of months later for an update. At this time I was advised that Detective Sackman was attempting to obtain my mothers medical files but that the Gosport War Memorial Hospital appeared to be reluctant to release them. The next thing we were told was that he had subsequently managed to obtain the files and he would continue with his investigations and inform us of the outcome.

At the beginning of 2002 we were contacted by Detective Superintendent James who advised that the enquires were complete and no further action would be taken. We have since had a meeting with Detective Superintendent James who explained his reasoning behind his failure to progress this case with the Crown Prosecution Service. His reasoning was, I feel, inadequate to say the least.

I am completely dissatisfied with the lack of investigation that has actually taken place and Detective Superintendent James' failure to do his job properly. The first point I would like to make is that at no time has Detective Superintendent James approached either myself or my two daughters to take statements from us or to even ascertain what our complaint entailed. How can you conduct a full investigation without even knowing the full details of our case?

I am also most dissatisfied by the fact that we were advised many months later that the Police had been 'investigating' my mothers case and commissioning expert reports without our knowledge. I dispute that this constitutes a full investigation and

feel that we should have at least been kept informed of the progress of the case. I do not accept Detective Superintendent James' excuse that he did not wish to cause us unnecessary anxiety. I can tell you that we were feeling anxious and frustrated by the lack of communication from yourselves.

I am also unhappy with the way in which Detective Superintendent James has handled this case. In addition to his failure to investigate this properly in the first place, I cannot accept his reasoning for not pursuing the case any further when the evidence is so obvious. Detective Superintendent James sat in my home and told me and my daughters that the two expert opinions who had looked at my mothers case agreed that there were discrepancies in the standard of care she received and in the administering of Diamorphine drugs via a syringe driver. He told us that the standard of care my mother received was sub-standard and that the administering of the diamorphine raised serious questions. James' reasoning behind not pursuing this case any further despite this evidence boiled down to a 'lack of police resources' and wishing to avoid unnecessary anxiety to other families which would need to be investigated. This is completely unacceptable and I suggest to you that this has more to do with a cover up and unwillingness to pursue these blatant cases of unlawful killings at the Gosport War Memorial Hospital. Again, I return to my point that despite what James' claim that the full investigation did not return sufficient evidence for a criminal conviction is unsubstantiated as we have never even provided statements of the events which took place.

Detective Superintendent James also advised us that he would arrange for us to obtain copies of the expert reports so that we could take whatever action we saw fit. Imagine my distress when just two days later I received a letter from James stating that we were not in fact entitled to these records without first obtaining a court order. I ask you what is there in these files that you feel the need to hide from us? My other point is did James check his facts with the force solicitor before advising us that we were entitled to these files? This was complete incompetence.

I am not prepared to accept Detective Superintendent James' feeble excuses regarding this case and I am not prepared to accept that this case will not be pursued any further. There is, I believe, a clear cut case to answer and I feel that in light of Detective Superintendent James' rank, his handling of this case is inadequate and constitutes a gross negligence of his duties.

I cannot express my dissatisfaction enough. I expect appropriate action to be taken in this case including opening it to further investigation. I would also like for you to explain to me why Detective Superintendent James has failed to complete this investigation correctly.

Yours sincerely

pp. Code A

Mrs Marilyn Jackson

CC: Police Complaints Authority
David Blunkett MP
Iain Duncan Smith MP
Peter Viggers MP
General Medical Council

In return please quote HM/FPD/2002/0941

15 April 2002

GENERAL MEDICAL COUNCIL

Protecting patients, guiding doctors

Code A

Dear Mrs Jackson

Thank you for your letter dated 11 April 2002, the content of which is receiving attention and we shall write again as soon as possible.

This case has been allocated the following reference number **HM/FPD/2002/0941.** It would be very helpful if you could quote this reference number whenever you write or speak to us.

If you have any questions please contact me or the officer in charge of this case, who is, **Helen Morran, Tel:** Code A

Yours Sincerely

Code A

Thomas Wood
Fitness to Practise Directorate

Code A

178 Great Portland Street London W1W 5JE Telephone 020 7580 7642 Fax 020 7915 3641
email gmc@gmc-uk.org www.gmc-uk.org
Registered Charity No. 1089278

In reply please quote FPD 2002/0941

17 April 2002

GENERAL MEDICAL COUNCIL

Protecting patients, guiding doctors

Code A

Dear Mrs Jackson

Thank you for your letter of 11 April 2002 about Dr Jane Barton.

I have enclosed a leaflet which explains the GMC's remit and how we assess complaints and I hope you find this information helpful. It is important that you read it so that you understand from the outset what we can, and cannot, do. Our role is to license doctors to practise in the United Kingdom. Although we provide guidance to doctors about what constitutes good medical practice, not all alleged breaches of that guidance will warrant formal action by us. We have power to take action against a doctor *only* where their behaviour justifies our restricting or removing their permission to practise medicine. In legal terms this behaviour is described as 'serious professional misconduct' or 'seriously deficient performance'. In short, we are able to use our powers where we consider a doctor to be a threat to patients' health or well-being.

I should explain that no decision has yet been made about whether we can take action on the matters which you have raised. To help us decide whether we can assist, please complete the attached consent form and return it to us by 2 May 2002. If you answer no to any of the questions on the form it is unlikely that we can take this matter forward. I am also enclosing a form requesting your permission for us to obtain copies of your late mother's medical records as they will be relevant to our consideration of your complaint. These forms should be completed and returned in the envelope provided. However, if you already have copies of your mother's medical records in your possession, please send them to us as soon as you can.

I am afraid that we are unable to consider your complaint about Phillip Beed as he is not a doctor and falls outside our jurisdiction. If Mr Beed is a nurse, you should contact the UKCC, who have responsibility for considering complaints about the conduct of nurses, at the address below:

United Kingdom Central Council for Nursing Midwifery & Health Visiting (UKCC)
23 Portland Place

178 Great Portland Street London W1W 5JE Telephone 020 7580 7642 Fax 020 7915 3641
email gmc@gmc-uk.org www.gmc-uk.org

London
W1N 3AF
Tel: 020 7637 7181
Fax: 020 7436 2924

Upon receipt of your reply, we will give further consideration to the matters you have raised. Your enquiry has been allocated the reference number FPD 2002/0941. It would be very helpful if you could quote this reference when you write or speak to us.

Yours sincerely

Code A

Code A

Your ref:

Our ref: 2002/0941

24 May 2002

First Class Post

Mrs M Jackson

Code A

GENERAL MEDICAL COUNCIL

Protecting patients, guiding doctors

Dear Mrs Jackson

Drs Jane Barton and Althea Lord

I am writing regarding the complaint you made to the GMC about Dr Barton and Dr Lord. Please accept my apologies for the delay in updating you on our consideration of your complaint.

As you are aware the circumstances surrounding your mother's death were reviewed by Hampshire Constabulary. Once it had been established that no charges would be brought, the police passed their case papers to the GMC to consider whether, issues of criminality aside, there were any matters of professional performance or misconduct which warranted formal consideration under our fitness to practise procedures.

This information, together with your letter of 11 April 2002, has now been reviewed by both a medical and non-medical member of the Council responsible for considering complaints and information about doctors. Both members were sorry to learn of your mother's death and have asked me to pass on their condolences.

I have also been asked to explain that the Medical Act 1983 (as amended) gives the GMC powers to take formal action in response to a complaint or information about the conduct or performance of an individual registered doctor *only* where there is evidence that the doctor's behaviour is so serious that it could justify restricting or removing the doctors registration. The Act describes behaviour of this sort as "serious professional misconduct" or "seriously deficient performance". Whilst not specifically defined in the Act a generally accepted definition of these terms is conduct or performance which is so seriously below the standard expected of a doctor that it calls into question the doctor's right to registration.

Whilst acknowledging that Dr Lord was the consultant in charge of your mother's care following her transfer from Queen Alexandra Hospital to the Gosport War Memorial Hospital, the members noted that day-to-day medical care was the responsibility of the clinical assistant, Dr Barton and the ward nursing staff.

178 Great Portland Street London W1W 5JE Telephone 020 7580 7642 Fax 020 7915 3641
email gmc@gmc-uk.org www.gmc-uk.org
Registered Charity No. 1089278

According to the medical records Dr Lord only saw your mother once, whilst on Daedalus ward and on that occasion carried out what the members considered to be a reasonable assessment of your mother's condition with a plan to review her placement needs in a months time. Having carefully studied all the information provided the members do not consider that Dr Lord's actions you raise any issue which could be regarded so serious as to justify formal proceedings which may result in the restriction or removal of his registration.

However, the members did consider that the information received from Hampshire Constabulary contained prima facie evidence of misconduct on the part of Dr Barton and it was therefore decided that the matter be referred to our Preliminary Proceeding Committee for further consideration. We shall inform you of when this will take place in a separate letter. As the Council's deliberations at this stage of our procedures is private, I would ask you not to disclose this information to any other persons.

Code A

Michael Hudspith
Fitness to Practise Directorate

Code A

12.6.02.

Code A

rd. 2002/0941.

Dear Mr Murphy.

With reference to our telephone call yesterday.

I am writing to ask you if it is possible that you would be able to get the Police reports on my Mother.

It seems that everybody has been able to see them apart from myself and family.

This seems very unfair and makes me wonder what is being covered up.

I do hope you will be able to help.

Yours Sincerly

Code A

Your reference:

Our reference: 2002/0941

21 June 2002

First Class Post

GENERAL MEDICAL COUNCIL

Protecting patients, guiding doctors

Code A

Dear Mrs Jackson

Mrs Alice Wilkie

I write further to your letter of 12 June 2002. Please accept my apologies for the delay in responding.

I have now had an opportunity to speak with Hampshire Constabulary and taken advice from both senior colleagues and our own solicitors about disclosing to you copies of the expert opinions prepared during the recent police investigation.

As with all record holders, the GMC is bound by the terms and conditions of the Data Protection Act 1998 when deciding how and why personal data is processed. Personal data is information about identifiable, living individuals and includes both facts and opinions about the individual. Processing incorporates the concepts of 'obtaining', holding' and 'disclosing' information.

I am advised that, were we to release these documents to you, we may be violating the rights of data subjects (certain individuals named in the documents). I am afraid therefore that due to restrictions placed upon us by the Data Protection Act we are unable, at this time, to disclose the information you have requested.

That said, I am also advised that under the Data Protection Act we can provide personal information to a third party if required to do so by a court order. Should you wish to consider pursuing this option, you should approach a solicitor for advice.

I am sorry that I can not be of further help at this time.

Code A

Michael Hudspith
Fitness to Practise Directorate

Code A

178 Great Portland Street London W1W 5JE Telephone 020 7580 7642 Fax 020 7915 3641
email gmc@gmc-uk.org www.gmc-uk.org
Registered Charity No. 1089278

Your ref:

In reply please quote: ~~2000/2047~~ 2002/0941

11 July 2002

First Class Post

GENERAL MEDICAL COUNCIL

Protecting patients, guiding doctors

Code A

Dear Mrs Jackson

Dr Jane Barton (1587920)

I write further to your previous correspondence regarding Dr Barton.

I am now able to confirm that, in relation to the information received from Hampshire Constabulary relating to Mrs Wilkie's clinical care, a case against Dr Barton is scheduled to be considered on 29 - 30 August 2002 at a meeting of the Council's Preliminary Proceedings Committee. It will be for that Committee to decide whether the doctor should be referred to the Professional Conduct Committee on a charge of serious professional misconduct.

Should the Committee decide that the case raises no issue of serious professional misconduct, they may conclude the matter by issuing a warning or advisory letter to the doctor about her future conduct, or decide to take no action. Please note that the relevant Trusts and Health Authorities have also been notified. We will write to you again after the Committee meeting to inform you of our decision.

As the Council's deliberations at this stage of our procedures is private, I would ask you not to disclose this information to any other persons.

Code A

Michael Hudspith
Fitness to Practise Directorate

Code A

178 Great Portland Street London W1W 5JE Telephone 020 7580 7642 Fax 020 7915 3641
email gmc@gmc-uk.org www.gmc-uk.org
Registered Charity No. 1089278

P72

DOCUMENT RECORD PRINT

Officer's Report

Number: R7DA

TO: REF:
STN/DEPT:

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

SUBJECT: DATE: 29/04/2004

I visited Marilyn JACKSON at her home address on 11/02/2004. Present at the meeting were her daughters Emily YATES and Lisa PAYNE. The family had the opportunity to compare the copy of Alice WILKIE's medical records as supplied by the police against their copy of Alice WILKIE's records as supplied by the local health authority.

The family will say that Alice was born in the London area on **Code A** she was one of six children.

She married Albert WILKIE and had one child, Marilyn and adopted a son, Andrew. She worked initially as a tailoress and subsequently in grocers and newsagent type shops. She moved to Arundel upon her retirement with her husband and upon his death she moved to the Gosport area and lived with her daughter.

With regards to her medical history, the family can say that at some point whilst in her late 50's, early 60's Alice was checked for TB and as a result had part of a lung removed.

When she moved to Gosport in 1992 she was displaying signs of dementia.

She had an ulcer and was passing blood that was successfully treated.

Alice's doctor was Dr Yeo from the Gosport Health Centre.

Her dementia grew progressively worse and in 1997 she went to live in Addenbrook Residential Care Home for Dementia.

On 31/07/1998 Alice was admitted to the Queen Alexandra Hospital suffering from dehydration. She had a UTI infection which had not responded to antibiotics and had been admitted to resolve the problem.

She responded well to treatment and on 6th August 1998 (06/08/1998) was transferred to Daedalus Ward at the Gosport War Memorial Hospital for rehabilitation and a 4/6 week assessment of her condition.

When visited by her daughter on the day of her admission, she was sat having her tea and feeding herself.

By the weekend, the family describe her as an 'empty shell' she would just sit like a 'zombie'.

She had been admitted mobile but by the weekend had to be moved with the aid of a hoist.

Within days she had become bed bound. Mrs JACKSON spoke with a nurse she believes was named JOYCE (surname) who told her that her mother was deteriorating.

On 17th August 1998 (17/08/1998) Mrs JACKSON received a telephone call from the hospital from Phillip BEAD asking her to "come in for a chat".

He told her that her mother wasn't very well and Mrs JACKSON was concerned as she didn't want her mother to suffer any pain.

Mrs JACKSON was of the opinion that something 'wasn't right' but she didn't get the impression from the meeting that her mother's death was imminent.

Mrs JACKSON would visit at different times of the day and she noticed that the trays of food for patients were left out of reach of the patients and that the food was unsuitable. Her mother was given, thick dry sandwiches which she couldn't chew.

On 20th August 1998 (20/08/1998) Mrs JACKSON visited her mother during the morning. She describes her mother as being very sleepy and appeared to be in discomfort. She asked her mother if she was in pain and her mother told her that she was. Mrs JACKSON approached a member of staff, she believes it was a SN JOYCE and asked her to check her mother.

She waited for an hour and no nurse came so she approached Phillip BEAD who told her that "We'll give you mum something for the pain, it will make her sleepy but she will hear you and she'll know what's going on".

Mrs JACKSON left the hospital at 1400 hours and rang Lisa, her daughter. She asked her to go and check on Alice.

Lisa PAYNE went to the hospital and asked about her grandmother, she was told "Your mother seems to think that she's in pain".

Lisa states that at this point Alice was sleeping peacefully.

At 2000 hrs Mrs JACKSON returned to the hospital, she found her mother to be unconscious, she didn't move or respond to anything.

Mrs JACKSON and her family stayed with Alice throughout the night, it was at this point that they met Mrs G McKENZIE and Mrs L RICHARDS who were visiting their mother.

Alice WILKIE never woke up and her breathing was quiet and shallow.

The night staff offered Mrs JACKSON a bed for the night, she describes them as being very nice.

During the early part of the morning the curtains, which were drawn around Alice's bed, were pulled back and a woman, who is believed to be Dr BARTON , looked in and said "Won't be long now".

Mrs JACKSON recalls that her mother's catheter bag was full of blood.

Around tea time, Phillip BEAD told Mrs JACKSON to go and get some rest as she may have another night of sitting with her mother. Mrs JACKSON would only go after being assured that she would be notified if there was any change in her mother's condition.

The family then left and went to get something to eat, they arrived back on the ward at 1830 hrs, they saw Phillip BEAD, who moved quickly into Alice's room and as they arrived at her door he said "She's heard your voice, she's just gone". The family describe Alice as looking 'yellow and waxy' they do not believe that she had only just died.

Their concerns are as follows;

The speed from which Alice was well/walking to being in a comatose state.

They were not aware that a syringe driver was in use.

No one spoke to the family about pain relief for Alice.

They received no warning or communication as to the severity of 'Alice's' condition.

The family have read the police copy of Alice WILKIE's medical files and wish to point out the following.

1. Pg 64, with reference to the dosage of diamorphine and medazolam, they query the times this was given.

2. Pg 88 Dr LORD has written DNR (Do not resuscitate) the family were not consulted over this decision.

3. Missing page from police records for 04/08/1998 - 21/08/1998, should be between pages 88-89 (page copied and exhibited EY/AW/1 - sent to clinical team).

4. Page 125, entry dated 17/08/1998, family dispute this, Mrs JACKSON states this did not happen, she was not consulted.

5. Entry as 21/08/1998, 1830, family dispute the time of death.

6. Pg 115 entry 06/08/1998 refers to 4/6 weeks assessment, no indication of impending death.

7. Pg 140 13/08/1998 entry written in error relating to medication given to Gladys RICHARDS .

8. 19/08/1988 entry for death of Gladys RICHARDS. The family is concerned that Alice WILKIE received medication intended for Gladys RICHARDS.

9. QA records show Alice eating and drinking, GWMH records have no records to this effect. There are no fluid input/output charts.

10. Pg 113 Carer contact numbers are wrong.

11. Death Certificate gives cause of death as dementia and pneumonia. The family were informed Alice had pneumonia nor is there any indication in the medical notes.

12. Why was Alice not seen by a Dr from 10/08/1998 - 21/08/1998.

13. Pg 25 dated 17/8 who decided that active treatment was not appropriate and why? Is this a nurses job?

14. 20/08/1998 who checked for the pain as indicated by Mrs JACKSON?

15. Why was the analgesic ladder never used?

16. Who prescribed diamorphine?

17. Why was there such a lack of communication?

General Medical Council

Dr Jane Barton

Statement of Gillian MacKenzie

I, **Gillian MacKenzie**, will say as follows:

1. I am the eldest daughter of the late Mrs Gladys Richards and the sister of Lesley Lack.

2. I make this statement in relation to the General Medical Council's investigation concerning Dr Jane Barton. I have previously given accounts to the police in relation to the care received by my mother. On 17 August 1998, before my mother died, my sister and I started the complaints procedure at the hospital which generated some correspondence. I later completed an investigation information form for the Commission for Healthcare Improvement (10 December 2001) and I attended an interview with them in London. I have also, since the death of my mother, had access to records and documents which I have reviewed but my access to them has been limited, some of them I only obtained in 2004. (Some of the comments I made on the records I was shown were not subsequently included in police statements.)

3. I previously assisted the Hampshire Police with their investigations. Exhibited to this statement and marked as follows are copies of my various witness statements and interviews transcripts:-

   (a) "**GM/1**" – witness statement prepared by the police in accordance with my dictation signed and dated 27 April 1999. This statement was primarily in relation to my complaint about the first two investigations by Gosport Police. It was made to officers from the Professional Standards Department as a result of my letter to Sir John Hoddinott on 20 November 1998.

   (b) "**GM/2**"– transcript of first interview with DCI Ray Burt 17 November 1999.

   (c) "**GM/3**" – transcript of second interview with DCI Ray Burt 17 November 1999

   The interview was recorded at my suggestion to assist with the preparation of my statement.

   (d) "**GM/4**" –witness statement prepared by the police on my behalf signed and

dated 6 March 2000 (after I had made corrections to earlier drafts).

4. I also attach:-

(a) "**GM/5**" – investigation information form for the Commission for Healthcare Improvement

(b) "**GM/6**" – my notes on the reverse side of A3 photocopies of the Gosport War Memorial medical records (and Dr Lord's report). These were made in 2004 after I had received copies of the notes from the police.

(c) "**GM/7**" – A police transcript of my handwritten letter to Superintendent Williams dated 19 January 2005 attaching my comments on the Haslar medical records. [The police should have the original letter and comments].

(d) "**GM/8A**" – Original notes and comments which formed complaint/questions to the Trust in my sister's handwriting but jointly compiled by us both [YET TO BE LOCATED]

(e) "**GM/8B**" – Police document containing (in typed text) our questions/comments and the Trust's response – with handwritten annotations by me with my response/comments (as requested by police)

5. The police interviews and my police witness statements cover a large number of issues. They include details of my wide ranging concerns about the care provided to my mother and my particular concerns about the circumstances of my mother's death (and her subsequent death certificate) and the Gosport War Memorial Hospital. I was also given an opportunity to comment on medical records and some of the material obtained by the police in the course of their investigation (although not until 2003/4).

6. I understand that this statement is for the purposes of the General Medical Council's investigation concerning Dr Jane Barton and therefore whilst some of the background information may assist this statement primarily deals with the involvement of Dr Jane Barton and matters which I have directly witnessed.

7. Before I married my career was in personnel management and for a brief period in 1978, for about 18 months, I did some further work in personnel management. To the extent that I comment on medical records or treatment in this or my police statements I can only provide my lay opinion. I have come across and informally studied some medical and legal issues as result of my interest in law, psychology and psychotherapy, attending workshops, short courses etc. training, at Sussex University, Colleges & Further Gen. Education, Cruse (Bereavement)

Background

8. I live in Eastbourne and I am currently 74 years of age. I approximately four and half years older than my sister Lesley from whom I was estranged from around the age of 25.

9. Since my father's death in 1974 my mother lived either in close proximity to my sister or in nursing homes. My sister is a nurse and my mother resided with her whilst she was manager of a number of nursing homes. They lived separately from the nursing home, although in Basingstoke my mother had to move into a warden assisted flat and eventually into the Nursing Home itself.

10. In around 1993/4 my mother transferred to "Glen Heathers" nursing home in Lee-on-Solent. I was not told about the move at the time but once I had tracked her down I occasionally went to visit her there. She always used to recognise me although over time she grew frailer. When I visited I would take her out to lunch.

11. I remember visiting on her ninetieth birthday (13 April 1997) when there was a party in the nursing home. I recall her being able to hold a conversation and she was perfectly normal.

12. According to my sister in around January 1998 my mother deteriorated and become unwell. I went to see her in around February 1998 and several times after that and, as set out in my police documentation, at around that time, in April 1998 I went to visit her general practitioner Dr Bassett to discuss the prescribing of tranquilisers and other medication (which seemed to be a cocktail of contradictory drugs).

13. From around January 1998 I went to see my mother more often as Lesley was on holiday and I did not want her to feel abandoned. I noticed then that my mother seemed to be more confused. She was agitated and unsteady on her feet and I have since learned she had had a number of falls. I was concerned about the effect of the drugs she was having and was unsure whether her confusion was due to that or dementia.

14. One difficulty my mother had with conversation and disorientation was because she had lost her hearing aids and her glasses in the Nursing Home. She also had bad cataracts and had lost much of her sight in one eye.

Admission to Haslar Hospital

15. I recall receiving a telephone call on 30 July 1998 from my niece Mrs Karen Reed informing me that my mother had been admitted to Haslar Hospital and was shortly to have an operation for a broken hip. I learned that she had had a fall in the nursing

home. I immediately attended, driving down from Eastbourne and was able to stay with her during her admission to the Haslar Hospital from 30 July to 11 August, apart from on two days when I returned to Eastbourne.

16. While she was in the Haslar Hospital my mother was noticeably more alert than she had been in January 1998. I attribute this to her being on less medication.

17. In the Haslar Hospital her food and liquid intake and her urine output were carefully monitored. At one point she was on a drip and a catheter. She was eating well.

18. As she made progress at the Haslar Hospital she was able to walk the length of the ward using a zimmer frame and accompanied by a nurse on either side.

19. Towards the end of my mother's time at Haslar Hospital we were introduced to Dr Reid (I believe Dr Lord was away). My sister and I had mentioned to the staff at Haslar that we did not wish our mother to return to the Glen Heathers nursing home. We both thought she should go to another nursing home. Accordingly the Hospital called in Dr Reid who was medical director of the Portsmouth Healthcare Trust. At that time Haslar Hospital were ready to discharge my mother back to the nursing home. Dr Reid came in to assess whether she could instead be admitted to the Gosport War Memorial Hospital.

20. It was decided that my mother could be sent to the Gosport War Memorial Hospital for rehabilitation while we used the time to find an alternative nursing home. The surgeon thought she should go there for two to four weeks. We asked Dr Reid if it could be longer, perhaps six weeks if we needed more time to find an alternative nursing home.

21. By the end of her time at Haslar Hospital mother was more alert than she had been and, although she could not speak coherently in long sentences, she could make herself understood. She was also eating well. I understand that Haslar Hospital had stopped giving her the Trazodone drug that she had been receiving at the nursing home. She was still receiving Haloperidol at night. I have previously expressed my view that the staff at the Haslar were fantastic and did a good job of looking after my mother.

22. Having been to see Gosport War Memorial Hospital on the Saturday I came home shortly before my mother was transferred to the Gosport War Memorial Hospital on Tuesday 11 August 1998. On transfer my mother was accompanied by my sister who I believe must have given as my mother's history a diagnosis of Alzheimer's. There is nothing on the medical files going back 10 years that this medical diagnosis was ever made.

Gosport War Memorial

23. Prior to my mother's admission to Gosport War Memorial Hospital my sister and I went to see the hospital and were shown a room with a big glass window, opposite the nursing desk. I recall that we discussed the possibility that my mother, who remained independent to some extent, might seek to get up to go to the toilet and might fall. I felt this room was better than a ward bed as the nursing staff would see if she tried to get up and if she fell.

24. Initially after my mother had transferred to the War Memorial Hospital I had a call from sister saying that she had settled in well. On the second day Lesley was more concerned and described her as "zonked out".

25. Within a couple of days I had a late night phone call from my sister who was distressed and told me that my mother had had a fall.

26. I travelled back to Gosport the following morning and found that my mother had been transferred back to the Haslar Hospital having required her hip to be manipulated back in place. After she returned from the operating theatre (under IV sedation) she was quite groggy and took some time to recognise me and to process information. I am concerned that the Haslar Hospital had not been fully informed as to her medication whilst at the Gosport War Memorial Hospital. However, during that two or three days she made a good recovery and was quite alert. I believe it was mentioned to Lesley by one of the Accident and Emergency surgeons that she was dehydrated. She was kept in Haslar for two or three further days before being returned to the Gosport War Memorial Hospital.

27. I was concerned about what had happened to my mother at Gosport War Memorial Hospital and I had not seen her there myself. However, having spoken to Lesley it was decided by Haslar Hospital that my mother would go back to Gosport.

28. It was my understanding that during her stay at Gosport between 11 and 14 August 1998 my mother had been sedated (as she had been at the nursing home); this time she had received oramorph (according to the drug charts).

29. On 17 August my mother transferred back to the Gosport War Memorial Hospital. My sister and I arrived there to visit her at about 12.15 having been told she would be there at approximately 12 o'clock. As soon as we went through the doors of the ward we could hear mother moaning and to me it appeared that she was moaning in pain. My sister commented to me that mother had made such noises at the nursing home in order to attract attention.

30. She was making a loud groaning noise, she sounded in pain. I can clearly picture

arriving at her bed. The bed was against the wall. My mother was not lying back, she had her legs in front of her but angled towards the wall and she was having to twist to be fed by the care worker. She had a sheet and possibly a blanket on top of her. I pulled back the bed clothes because I was concerned by her apparent pain. Her legs were not straight and her entire weight was placed on her right hip as a result of this position.

31. At the time she was being fed by a care assistant and I therefore went out on to the corridor and asked for a qualified nurse. I believe nurse Margaret Couchman came to assist Lesley move mother and place a pillow between her legs. I have described this in more detail in my police documentation. Both my sister and I remained with my mother throughout this time.

32. After my mother had been made more comfortable we met the nurse manager Phillip Beed. He acknowledged that my mother was in considerable pain. Lesley went out of the room (I think that she may have gone to contact Haslar). Mr Beed then returned with an injection. I asked him what it was and he said "diamorphine". I said very strongly that mother should not be given diamorphine as we did not know what was wrong with her. I suggested she should be given something else. I said that I hoped we were not thinking about euthanasia here as I would not tolerate that. It seemed to me that diamorphine was a very strong medication to be giving when my mother had still not been seen by the doctor. Mr Beed then left the room and while he was gone Lesley returned she said she understood I had had a word with Mr Beed and that he was just doing his job. I said not with diamorphine. Mr Beed returned and gave my mother an injection which I understood was to ease the pain, I assumed it was not diamorphine given our earlier conversation. That injection which I witnessed does not appear on the drug chart. My Sister, Mrs Lack, also witnessed that injection given

33. Mr Beed then tried to make arrangements for my mother to have further x-rays. There were some difficulties with the paper work for the x-ray which are set out in my police documentation. Eventually Dr Barton came to the ward at about 3.30pm. We were asked to leave while she examined my mother. She came out and said that they would arrange for x-rays.

34. At this stage my mother was still conscious. My sister and I accompanied her to the x-ray department. I remember I was holding my mother's hand very tightly. Her fingernails were in my hand and she appeared to be in a lot of pain and did not want me to leave her. My sister was going to go into the x-ray department but was told she could not go in. We waited outside and could hear my mother moaning and then there was silence.

35. When my mother came out of the x-ray department she appeared unconscious. We asked what had been seen on the x-ray and my sister specifically asked if she could see

the x-ray. She was told she could not. The people present for this conversation were just Lesley and I and the radiologist, my mother was there but not conscious.

36. We returned to my mother's room and I saw Dr Barton go past my mother's door and I went out after her. Lesley and I followed her down the corridor and asked her what had happened. By this stage (before going down to the x-ray department) my sister Lesley had been making enquiries about whether our mother could be readmitted to the Haslar Hospital and Lesley had been told they were prepared to have her back.

37. In our conversation with Dr Barton we were told that mother had not dislocated her hip again? Lesley mentioned that the Haslar Hospital were prepared to have my mother back; Dr Barton appeared to be annoyed when she mentioned this. She looked annoyed or angry from her facial expression and said words to the effect that our mother was her patient and she thought our mother had had more than enough trauma for one day. She indicated she would decide what would happen to her.

38. We were told by Dr Barton that there would be a review the following morning and in the meantime the hospital would seek to keep our mother pain free overnight and we should return early at about 9am the next day. This conversation was between me, my sister and Dr Barton, no-one else was present in the corridor. We stayed quite late on the Monday. Lesley went home about 9pm or 10pm., I stayed a little longer. Mother did not open her eyes during that day once she had come out of the x-ray department.

39. We arrived back early on the Tuesday morning and Mr Phillip Beed asked us to go into his office. (I think that my sister and I had different impressions of him, I did not take to him from the first moment I saw him whilst Lesley thought he was wonderful.)

40. We were sat in the office when Mr Beed told us that our mother had a massive haematoma and that there was nothing further that could be done. My immediate interpretation was that she had suffered a massive haemorrhage and I expressed that I would like mother to go back to the Haslar Hospital. Lesley asked if there was anything that could be done and Mr Beed said the only thing they could do was to ensure that mother had a pain free death. He said he proposed to put her on a syringe driver with diamorphine.

41. My sister was very upset by this but we were told that there was nothing we could do. I reiterated that I would like mother to go back to the Haslar Hospital unless she was so close to dying that it was thought she might die in the ambulance. Mr Beed said that that was possible and I said that, in that situation, she should stay at the Gosport War Memorial Hospital.

42. I recall Lesley asked what could be done for a haematoma but Mr Beed's reply was that nothing could be done. I am sure that there was no mention of any surgery or a

general anaesthetic.

43. My sister and I were given the impression that our mother was very close to death and I assumed that the hospital would not start a syringe driver with morphine until a patient was indeed very close to death. (I spent time at the Royal Marsden hospital when my husband was admitted and had therefore learned about syringe drivers and this treatment over a period of two years). We went back to sit with our mother and Phillip Beed came in and set up the diamorphine. We "agreed" to this treatment because we thought she was very close to dying.

44. Lesley was greatly upset about the diamorphine because we understood that mother would not regain consciousness or see us and that we would not have a chance to have a conversation with her again.

45. However we sat with our mother and I spoke to her a bit that day, hoping she might hear my voice. During this time Lesley telephoned members of the family and later her youngest daughter (my niece) arrived with her baby.

46. We saw Dr Barton that morning at around 11:30am. I was there with my sister, my niece and the baby. Dr Barton came to the doorway of the room and made a comment about the baby being there. She said words to the effect that she presumed things had been explained to us about the syringe driver. We indicated that they had. We were both aware of the use of syringe drivers in end of life situations.

47. Dr Barton then went on to tell us that we should expect a chest infection next. I thought that the comment about a chest infection was strange because if mother was so close to death I did not know if there would be time for her to get pneumonia, I was expecting her to die within a few hours; that was the impression we had both been given by Philip Beed.

48. There was no mention at all of any interventional surgery that might be undertaken to relieve the haematoma. I am confident that Dr Barton did not mention surgery as I have a clear recollection of our conversation. I am confident that there was no discussion about whether my mother would stand an anaesthetic, had such a conversation taken place it might have been relevant to refer to hip replacement and dislocation which had both been treated without general anaesthetic (they had been done under IV sedation).

49. That day, Tuesday 18 August, I stayed with my mother until very late (past midnight). My son arrived from London. When my son arrived Tuesday night/Wednesday morning he asked to see a doctor but was told there was no one to speak to.

50. On the Wednesday night my sister also sat with me all night long. We both remained

at Gosport War Memorial Hospital until Friday evening when my mother died.

51. I can confirm that my mother was never alone from the time she was placed on the syringe driver. After the conversation about a chest infection Dr Barton did not come and see her again to my knowledge, she certainly never came while I was there.

52. We were not attended to by the nursing staff to any great extent. When mother died I had to go out and find a nurse.

53. It was somewhat of a surprise to me that my mother survived until Friday night given that she had been placed on the diamorphine syringe driver on Tuesday. I had been given the impression that she would die within hours on the Tuesday. There is no mention on the medical file or Death Certificate of a haematoma theft.

Relevant Matters After My Mother's Death

54. When I got home after my mother had died, but before the funeral, I contacted (I believe) Mrs Humphreys at Gosport War Memorial Hospital to raise our concerns about my mother's treatment. My sister had made notes on behalf of us both (we were together as she wrote these) and had a number of questions (**GM8A**). I was particularly anxious to ask why a decision had been made for mother to only have painkilling medication and not any hydration. I was concerned that it had taken my mother five days to die and that dehydration would have contributed to her death. I was not satisfied with the report/answers produced and have outlined my concerns in the police documentation **GM8B**.

55. In my police interview I was taken to a number of documents which were prepared (not always by me) after my mother's death dealing with our concerns about her treatment. I gave my answers and explanations for those documents to the best of my ability at the time which can be seen in the police documentation.

56. I was concerned to hear that Dr Barton felt that the family had been involved at the stage where a decision was made to provide nothing but pain relief. I very specifically deny any suggestion that Dr Barton made us aware of the surgical intervention necessary for haematoma that would have required a general anaesthetic. This was never discussed at all, the only discussion we had about a haematoma was with Phillip Beed who indicated nothing could be done expect to give pain relief to provide a pain free death.

57. I have also discussed with the police concerns I had about the death certificate which gave the cause of death as pneumonia. On receiving a copy of the letter (the Trust response to our complaint/questions) from M Millet dated 22 September 1998 I spoke to Lesley. As a result of my concerns having spoken to Lesley, I telephoned Gosport police station on Sunday 27 September 1998.

58. My statement dated 27 April 1999 largely sets out a number of my concerns about the way the police investigated my concerns about my mother's death. I understand these are not directly relevant to the GMC investigation but they provide some further details. Eventually, after interviewing my sister in 2004 (when she made a statement about the cause of death) and my interview with the police in September 2005, Superintendent Williams informed me he agreed that my mother had not died on pneumonia, he had consulted with an expert and the conclusion was that my mother had died of dementia. I do not accept that this was her cause of death.

59. I understand that my statement may be used in evidence for the purposes of a hearing before the General Medical Council's Fitness to Practise Panel and for the purposes of any appeal, including any appeal by the Council for Healthcare Regulatory Excellence. I confirm that I am willing to attend the hearing to give evidence if asked to do so.

I believe that the facts stated in this witness statement are true.

Signed: Code A

Gillian MacKenzie

Dated: June 21 2008

General Medical Council

Dr. Jane Barton

Exhibit GM/1

This is the Exhibit marked "GM/1" referred to in the statement of Gillian McKenzie:-

- witness statement prepared by the police in accordance with my dictation signed and dated 27 April 1999

Code A

Code A

Code A

Code A

Code A

Code A

General Medical Council

Code A

Exhibit GM/2

This is the Exhibit marked "GM/2" referred to in the statement of Code A -

- transcript of first interview with Code A 17 November 1999

Code A

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Code A

Exhibit GM/4

This is the Exhibit marked "GM/4" referred to in the statement of Code A -

- witness statement prepared by the police on my behalf signed and dated 6 March 2000 (after I had made corrections to earlier drafts).

Code A

Code A

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General Medical Council

Dr. Jane Barton

Exhibit GM/5

This is the Exhibit marked "GM/5" referred to in the statement of Gillian McKenzie:-

- investigation information form for the Commission for Healthcare Improvement

Questionnaire

CHI

Gosport Investigation Information Form

Thank you for taking the time to complete this form. I below, which most accurately reflects your position.

CHI complaint

Public	*Profession*
Patient	Doctor
Relative of a patient	Nurse
Carer	Professional allied to medic
CHC member	Management
Voluntary group	Administrator
Other (please specify)	Ancillary worker
new Kin of Patient.	Social worker

Confidentiality:

We aim to treat information in a confidential way and to report it anonymously, but if CHI needs to quote specific information you provide, we will check the accuracy of it with you before it is included in our report. If our investigation leads to other action, for example, referral to a professional body, CHI's documents may be open to pubic scrutiny. That includes information sent to us and notes made during interviews.

1. Reason for commenting

circumstances of the death of my mother. Mrs G M Richards at the Gosport War Memorial Hospital August 1998. 3 year investigation by Hampshire Police after which I was informed there was a 'strong' case for possible prosecution. CPS (Treasury Counsel) concluded 'no likely conviction' - 1 Strong dissenting Expert medical evidence - a private obtained Prof. Livesley (Geriatric medicine)

2. What are the main points you would like CHI to take account of?

Drugs written up for patient admitted for rehabilitation and recovery. Doctors written comment "I am happy for Nursing staff to confirm death" when my mother was not terminal. Lack of general care by Nursing staff - duty of care - negligence (gross) Hygiene record Keeping - dehydration etc.

I am amazed that you cannot see the medical files or my statement to the Police - this can not be an investigation without the recorded facts in the medical file? You cannot see them otherwise Data Protection

3. Have you tried to bring the matters to the attention of any before? If yes, explain what happened?

Matters brought to attention Hampshire Police on receipt of letter from Chief Executive Portsmouth Healthcare Trust 22 Sept 1998. (after PHT internal investigation) Answers to questions raised as complaints not acceptable & in some cases inaccurate. Dubiful Death certificate giving cause of death as pneumonia. (Pts not aware of this until a month after death. No visible or audible signs of pneumonia. Dead man's rattle etc. 21.05 = death. 21.20.

4. Bearing in mind the role of the CHI investigation team, what issues do you think CHI needs to look at?

Medical Records (some missing) contradictory records in file. Internal investigation by Portsmouth Healthcare Trust. Training of staff in dealing with pain & Km - health & psychological knowledge. health & communication skills. Record keeping etc. Treatment of patients with palliative drugs who were not dying. Inappropriate drugs given.

Thank you for completing this form.

If you would like a copy of the report of the investigation, please provide your name and address below. Alternatively, you may include your name and address on a separate sheet of paper. This will maintain the confidentiality of information provided on this form.

Name Gillian M. Mackenzie

Code A

Date 10.12.01

General Medical Council

Dr. Jane Barton

Exhibit GM/6

This is the Exhibit marked "GM/6" referred to in the statement of Gillian McKenzie:-

- my notes on the reverse side of A3 photocopies of the Gosport War Memorial medical records (and Dr Lord's report). These were made in 2004 after I had received copies of the notes from the police.

29 JAN 2008

Code A

28.01.08.

Dear Ms. Hall.

Herewith the notes sent to Williams investigation team (2003-2006) which were not allowed to be put in statement form. I did a similar exercise with the Harlan file which included the comment by the Surgeon that my mother was to go to Cospir for 2-4 weeks while Healey + I searched for a Nursing Home. Dr. I. Reid agreed that this could be extended to 6 weeks if required. (Hardly a comment of my mother was at death's door) Did you receive the Harlan file?

Apologies for untried scribble — off to the Nursing Home again

Sincerely

Code A

PS. I think the comments on Reed are relevant — but Barbara Reed + Head should be in the Criminal Court!

Code A

Page 2 of 6

This is not correct. (See Drug chart)

Oramorph given by Pulp Beed. 11 August shortly after admission. V.S. plus 12 13 14 Aug. ssr. Lesley Hart informed me that she had complained on the 12.8.98 and mother was taken off it — she was not.

What time did my mother arrive at Gosport - I understood she was accompanied by Lesley. There was some route to commence oramorph despite he fact that he letter from Haslar to Aspen (typed up on the evening before discharge from Haslar) states painkiller PRN co-codamol. Has a Directive checked Haslar file which was missing from the papers sent to Forest? Do I have to ask as Lead Expert's Directive.

See also Baban's comments 14.8.98 Very sensitive to Oramorph Mother was not in the room! Page 29 of 714.

Oramorph written up by Baban 11.8.98. Beed quick off the mark. CH1 Report "No pain assessment procedures in place."

If my mother was very sensitive to oramorph why did Beed query and cease he dose?

Pain was not a problem — Beed does not know or choose to know he is dealing to a dementia patient and a seizure. Lesley was confirm a the Nursing Home notes confirm washing.

Code A

Code A

Page 1 of 1

Drugs written up without proper assessment - See Reid's letter - Hadar staff statements - Hadar file - My mother was transferred to Gospel "for 2-4 weeks" to give Lesley time to find a Suitable Nursing Home on discharge. See Hadar file notes.

Bashar notes. 11.8.98. "Not obviously in pain"
why did Reid administer Oramorph?
14.8.98. 'Fee not to claim last night' who told her (Bashar) that? She left at 13.30. previous day. See Gospel file.

My mother did not need a further surgical procedure. Bashar seems incapable of assessing the X-ray. It is not up to her to comment.

Bashar is convinced my mother is about to die. Drug appropriate for palliative care (last stages). I am not a medical expert but I did spend the best part of 2 years in Chungham every day) at the Royal Marsden. I was aware of the palliative care drugs for my husband - Neil were discussed fully with my husband and myself. I have also had experience as a volunteer "gofer" in the Isaac Hospice.

Code A

Code A

Page 50 of 117.

Why did my mother have to undergo an X-ray at Gosport. A GP. should be capable of recognising a dislocation. Neither was on the ward when my mother fell 13.8.98. Why didn't she examine my mother. I understood Karen Read saw my mother in the Day Room slowly after 4pm descended. Did she fall in the Day Room? Is that why they did not know how long she had been on the floor. Why was the Day Room unsupervised. There are discrepancies here. Why hasn't Karen Read been interviewed and not come forward? Karen Read one of Lesley's colleagues and an ex Haslar & Hopeful Nurse.

17.8.98.

Remained unresponsive to some loud, non-purposeful with diamorph 11.12.13.14 followed by IV Sedation. at Haslar.

"Only given morphine in severe pain". Read quick off the mark. My mother was not screaming, but I think she was in pain & groaning/moaning. She had been carried on a sheet from the ambulance 'tipped' onto the bed into the night hip. Read had been informed there was no canvas. A canvas or was on the back of the chair in my mother's room. Why didn't Read ensure that it was used to transfer my mother from the ambulance to the bed. See CHI Report and my Statement (Baldwin)

18.8.98.

"Still in great pain" Rubbish - She never regained consciousness from returning from X-ray approximately 4.30 17.8.98. See My mother was talking to me whilst I accompanied her to X-ray holding her hand. Lesley was here. She lost consciousness in X-ray. Read gave her an injection at 1pm and another just before she went down to X-ray approx. 3.45. You do not inject Morphine. See my Statements. I strongly question the Drug chart for 17.8.98 Mother received nothing after returning from X-ray and Lesley and I did not leave until circa 6.30pm. If mother was given morphine on the 18th. 2.30 am and 4.30 am did they wake her up to give it to her by mouth? Mother was 'out' when we arrived on the 18.8.98 slowly after 9 am on the 18.8.98 when we were interviewed by Read alone.

Code A

Code A

63 ♂ 7th.

How much did Code A administer when she came on + went off duty? Another 40mg or 20mg. Records
abysmal. Patient was not drowsy - she was 'out' from
11.15. 9th eyes + way. She never opened her eyes or shrugged.

Code A

Code A

Page 62 of 714.

Hyoscine given on 18? 8. 98. 400 mg. by Baad. Hyoscine dehydrates. Baatar does not mention it until he 21. 8. 98

Page 30 of 714. Baad jumped he gave aspirin

Hyoscine given 18? 19. 20 before Baatar's interviews.

Times & Syringe driver (from 18. 8. 98) not correct.

Syringe driver times do not coincide with times given on P. 63 of 714. I stayed overnight from the 18. 8. 98 onwards. see medical file and Healey from the 19. 8. 98. She can confirm Syringe driver 'replenished' but no note is in the. he times or the amounts given. If. Baad gave 400 mg in the Syringe Driver how much did Jane give at a different time.

P. 63 of 714.

Code A

Code A

Page 64 ¶ 714.

I find it extremely difficult to read the date but it seems that Beer Joice and Coleman gave up Hampshire in the Syringa Bruen at? 11.20. 10.45 & 11.00 & Joine gave more at 1800 1800 & 0800 then ammen?

See note on P. 63 ¶ 714?

Code A

P460 1 714.
written by P. Reed (?). My mother did not answer a
the 11.8.96 Hospital with a dislocated hip. Does how
careless can Reed be?

Code A

Code A

P.461 of 714.

My mother was not admitted on the 17.8.98 with a diagnosis of [redacted] bronchopneumonia following broken hip. Nor was treatment of Syrupe ~~dimor~~ driver given on the 20.8.98. It was set up on the 18th. It would have been 'normal' in palliative care for the Syrupe driver not to have been set up more than 24 hours before death. — only as a last resource even in cancer deaths is it not set up until the last few hours which sometimes lasts 24 hours but usually far less. I am not a medical expert but I have witnessed this on several occasions at the hospital (my husband + other patients) + another hospital in Essex with a cancer patient in the last few hours. They were not kept unconscious for days. I do not know why mother was unconscious near death on the 17 / 18 8.98.

Code A

Given to Lesley Lack for comments. None given except paragraph 9. — not adequate. 9

Re- late Gladys Richards - DOB **Code A**

I am writing this in response to Lesley Humphrey's written request on 17th December 1998. I am the Consultant of Daedalus ward to which Mrs. Richards was admitted as a patient for NHS Continuing Care. She had been assessed at Haslar by Dr. Ian Reid who had also spoken to her 2 daughters. (Letter attached - *Note 1*). My wards rounds for the Continuing Care patients in Gosport are fortnightly on Mondays as I cover both Daedalus and Dryad wards. I was on Study leave on the 17th and 18th August 98. During her 2 short stays on Daedalus Ward (11/8 to 14/8 and 17/8 to 21/8) I did not attend to Mrs. Richards at all, nor did I have any contact with her daughters and hence the comments made are from what I have gathered from her medical, psychiatry and nursing notes, Sue Hutchings report, the sequence of events as documented by Mrs. Lesley Lack (Mrs. Richards' daughter) and from discussions with Philip Beed (Charge Nurse, Daedalus) and Dr. Jane Barton (Clinical Assistant). I have not had access to the Haslar records. The written complaint from Mrs. Lesley Lack, the documentation of the investigations and Sue Hutchings report of 11/9/98 were first made available to me on the 17th December 98.

In brief the sequence of events that affected Mrs. Gladys Richards -
30/7/98 - fall in Nursing Home, admitted to Halsar where she underwent a right hemiarthroplasty
11/8/98 - admitted to NHS Continuing Care Daedalus ward, GWMH - able to mobilise with frame and 2 persons
13/8/98 - fall on ward
14/8/98 - right hip x-rayed and subsequent transfer back to Haslar arranged. The same day s Closed hip relocation of right hip hemiarthroplasty was carried out under IV sedation. Nursing transfer letter states "rather unresponsive following the sedation"
17/8/98 - returned to Daedalus ward. On admission in pain and distress and was screaming loudly. She was given 5mg of Oramorph at 1 p.m. after discussion with a daughter who was present. A further Xray was arranged the same day and a dislocation excluded. This is also confirmed in the Radiologist's report.
18/8/98 - decision made following discussion with both daughters to commence a syringe driver containing Diamorphine. Mrs. Richards had required 45 mg Oramorph in a 24 hour period but seemed to be in considerable pain, discomfort and distress.
This was reviewed and renewed daily till Mrs. Richards passed away on 21/8.

I have itemised my comments as follows:

1) **Use of Diamorphine via a Syringe Driver**
All the documentation available supports the fact that Mrs. Richards was in very severe pain and distress, screaming loudly on return to Daedalus ward on 17/8. An X-Ray that same day excluded a 2nd dislocation (confirmed by Radiologist's report) and it was decided by the medical and nursing staff that good pain control would be the aim of management.

As Mrs. Richards was demented, her pain control was discussed with one of her daughters who agreed that Oramorph (the oral liquid preparation of Morphine) was

Dr. Hand's Report. given after request from Report C.D.
Not an independent opinion. How did he CPS originally accept it?

Para. 1.
How is it that my mother's named consultant Dr. Hand was unaware of Lesley Humphries Report for Mr. Aulett. Paramount Healthcare Trust until her request on the 17 December. This paragraph is a Defence 'Dismissive' of the Philip Reed and Bauhan 'has not had access to Hasbro records' Surely she should have been aware of the Report and complaint before on 17 December 1998 when she was re named consultant, in charge of her ward and the complaint concerned two of her own staff, Charge Nurse Reed and Clinical Assistant Dr. Jane Bauhan. The behaviour of these two members of staff were extremely under her supervision.

Para 2.
No comments on her face on 13/8/98 on Drugs written up on answer 11/8/98 or Bauhan's comments 'Quite happy for Nursing staff to confirm death'. Obviously in defence of Bauhan. I have commented on P30 of 7th. rather unresponsive following sedation. Hand should have understood why. I was her daughter present at 1pm. Reed did not give her an example. It was only injection. See my Statement. queried when he came in with an injection of diamorphine which I would not allow. When he came in again with an injection I assumed it was not diamorphine but I now know you do not inject Oramorph. My mother had another injection before going to X ray. 45 mg. Oramorph in 24 hour period Did May cause my mother to consciousness every 4 hours to give her oramorph — Rubbish. See my notes P30 of 7th. Decision taken by Sympa Nurse on 15.8.98 discussion with Reed only. Bauhan was not present. We were informed by Reed nothing more could be done & presumably we would want to have a pain-free death. When I said I wanted her back in Hasbro I specifically asked Reed if she (my mother) could die in the ambulance he replied "It is possible" We were given the impression death was imminent & so agreed the Sympa drugs. My mother was still 'out' from the day before. She did not seem to be in considerable pain, discomfort or distress. The treatment was not reviewed daily. Staff commented latterly was surprised she was still alive on the 19th.

Para 3.
My mother was not screaming loudly — She was making groaning. I have used 'screaming' in my Statement but with more experience in the last 6 years. I know this is not correct. I have been an emergency patient to A+E after Nephropy (Kidney Stone) given pain relief 'pethidine' I was moaning but conscious & I sounded like my mother. My mother had been tipped off a chair onto her right hip. As she could not gain attention to her position I am not surprised she moaned or wailed loudly. See my Statement.

given. This has a short action and needs to be administered 4 hourly for adequate pain control. Inspite of a substantial dose a day later, pain and distress was still a problem. Adequate nursing care was difficult to provide.

If someone is in considerable pain after having received regular Oramorph then the next step up the anaelgesic ladder is Diamorphine. The syringe driver was chosen as it delivers a continuous dose of Diamorphine over a 24 hour period, and hence 4 hourly injections are not required. It was also possible to add in Haloperidol 5 mg/24hours into the syringe driver. Mrs. Richards had been on this prior to her initial admission to Haslar. This was to treat agitation which had been a problem in the Nursing Home and occasionally at night on Daedalus Ward. Due to her underlying dementia, and inability to communicate fully, her distress could have been due to an element of anxiety and hence Midazolam was added to the syringe driver as an anxiolytic.

The above anaelgesia and sedation was considered necessary for Mrs. Richards to keep her comfortable and aimed at addressing pain, anxiety and agitation.

2) Decision not to start intravenous fluids.

Having established with Mrs. Richards daughters that she required opiates for pain control, we were now in the situation of providing palliative care. Basic nursing care, including mouth care was not possible as Mrs. Richards could not understand and comply with requests and was also in considerable distress. In this instance parenteral fluids are often not used as they do not siginificantly alter the outcome. If this is necessary in order to keep the mouth dry and skin hydrated, it is done by the subcutaneous route only on NHS continuing care wards. Patients requiring intravenous fluids would need to be transferred to an acute bed at Haslar or QA. Mrs. Richards was 91 years of age, frail, confused and had been twice to Haisar for surgical procedures and hence a 3rd transfer back for intravenous fluids only would not have been appropriate. I do not feel that the lack of intravenous fluids for the 4 days that Mrs. Richards was on a syringe driver significantly altered the outcome.

The concern about the lack of intravenous fluids was not raised by either daughter on Daedalus ward prior to her death and isn't included in Mrs. Lacks' written comments/questions.

3) What was agreed with Mrs. Lack and Mrs. McKenzie

The administration of the 1st dose of Oramorph on 17/8 was discussed and agreed with a daughter prior to it being administered. Consent was obtained for the doses to be repeated to ensure adequate anaelgesia.. The administration of subcutaneous morphine via a syringe driver was discussed on 18/8 and agreed by both daughters. Both these discussions were carried out by C/N Philip Beed.

Dr.A.Lord, Consultant Geriatrician
22/12/98

Para 4.

Yes I agreed to cremorph as he 17 and I assumed That he injection on the 17 was cremorph (I have requested the drug sheet). A subcutaneous dose a day later 18.8.98. According to the Drug chart 18.8.98 10 mls. 012.30 ! and 0430. There were no signs & pain and distress — mother was still 'out' from the she had X ray on the 17.8.98.

Haloperidol had been written up on the 11.8.98. but not given by Bead who prefered to keep mother sedated by cremorph. my mother had Haloperidol at the Nursing Home for a good night's sleep but not this dose. The agitation experienced at the Nursing Home

Para 5 is not surprising — nor that I have no ful drug records for my mother from Basingstoke onwards I am surprised that she had any brain left at all after psychiatric drug abuse over a long period. When at exile was Wesley doing to allow him mother to be dosed with Nemeleptics plus chem drugs. I was only aware & drugs at her on Solect and I suspect she had been on them from Dec/Jan 98. Lesley & the GP were cautioned he various cocktails she had been on/off before. There are notes regarding my objections on medical notes kept on Solent GP & Nursing Home records. Inability to communicate, — no hearing aids or glasses — I can find no medical records & cataract removal at Woolfields from Basingstoke onwards or at her on Solent Side effects & neuroleptics can cause loss & coherent speech. Dr. Banks comments my mother was allergic to Methid and suggests aromatherapy & therapeutic touch.

Para 6. addressing pain anxiety & agitation. I was under the impression it was to give my mother a pain free imminent death.

Para 7 Much care could not be given Gospnt medical notes do not confirm — the reverse. Mrs Richards could not understand — She was unaware Hyponic would dehydrate as fluids — excretions would dry in mouth, lungs — also skin. It arises 'in out'. Often in coma mistimes but not at this dose level. My mother was not transferred to Hasler for a surgical procedure — the dislocation did not involve surgery. There was no mention & a 3rd transfer back intravenous drip would not have altered the outcome but it would have given a more comfortable death. Dehydration is extremely uncomfortable see previous BMA + letters to the Times from Medical Experts well explain. Jan 6-9 1999 Sent to Dr. Morgan

Para 8. No-lasting intravenous drip was not ordered by Lesley or myself we were under the impression from Bead Mother was about to die on the 18th. We were dismayed that it took 4 days. Lesley's notes were written 4 days before death.

Dr. Lord's Opinion continued. Cont. 11.

Para 9.

1st dose of oramorph was agreed on 17/8/98 with me. I thought it was in the injection given by Reed after refusing to let him use diamorphine.

Yes Wesley & I agreed to Syrup Dreen with Reed. see previous comments.

Lord places these discussions fully with Reed. There is no reference to Barton and general anesthesia for a haematoma as contained in Humphrey's Report or as confirmed by Reed to Dr. Maddison as per my statement 27.4.99 Lord would have known you do not treat a haematoma with surgery or a general anesthetic - and of course there is no write up in the medical notes or evidence of a haematoma. Lord makes no comments - in defence of Barton or Reed.

Barton, Reed and Lord are all covering for each other. Barton is guilty of negligence but in my opinion Reed is the worst of the lot.

Code A

General Medical Council

Dr. Jane Barton

Exhibit GM/7

This is the Exhibit marked "GM/7" referred to in the statement of Gillian McKenzie:-

- police transcript of my handwritten letter to Superintendent Williams dated 19 January 2005 attaching my comments on the Haslar medical records.

DOCUMENT RECORD PRINT

Other Document

Number: D1299

Title: LETTER AND ATTACHMENTS FROM GILLIAN MACKENZIE 19/1/2005

Code A

19.1.2005 (19/01/2005)

Dear Supt WILLIAMS

With no response to my request that I am dealt with by a different Police Officer than Kate ROBINSON I now enclose my written notes on the points I wish to make in any further statement.

From my experience and in my own opinion Kate ROBINSON is unable to cope with me. She is slow on the uptake on any logical query I make and it seems to me is more used to dealing with petty criminals of low IQ. I simply cannot communicate with her.

Why is it that after approaching the point of a cerebral vascular accident she then agrees to approach you concerning my queries on Dr LORD's report? She admits she has had 6/7 telephone calls on this subject since October 2004, when she does approach you, you agree to a statement. She will not confirm whether she has ever approached you before. She will not allow me to comment on any other points I have previously raised with her and I wish to liaise again, except Dr LORD's report in a statement. She will not allow the interview to be recorded because "There has been trouble with me and tapes before". She will not allow me to record the interview as this is against her human rights. She will not allow me to dictate a statement which she will prepare and I will sign before her departure. She will not allow me to be interviewed or cross questioned by a Detective at Gosport/Fareham before a statement is prepared because that is not the way she does things. When I pointed out this would save time and police costs as I could travel down the night before (at my expense) and be interviewed in the morning at Fareham that is not allowed. I have done this before at Gosport CID on two occasions.

As I have pointed out to you before in writing 6 August 2004 (06/08/2004) I have never had any feedback from Kate ROBINSON on any of the queries I have raised. No wonder you have had 72 phone calls, those dealt with by Owen KENNY, Nigel NIVEN, DC TENNISON have resulted in feedback, not so Kate ROBINSON. She may be a Dedicated Family Liaison Officer, she is not a Detective in my opinion.

When I queried 'Dedicated' Family Liaison Officer, should it have been designated Family Liaison Officer she replied 'No I am not a coconut'. She confirmed later she had to look up the difference between Designated and Dessicated.

I find it extremely stressful to cope with this level of education as she does with me and mine. There has been enough stress caused by the police over a period of 6 years. I now have in writing the alleged

comments of Mr READHEAD concerning Ray BURT, which has caused me a great deal of personal distress.

Yours sincerely

Gillian M MacKENZIE

PS I would be grateful for an acknowledgement of this letter and whether the points raised are of any value. Of course this does not apply to comment re Lesley.

PS I confirm I should not of relied on Lesley to comment fully, she did not want me to go to the police in the first place.

Dr LORD's Report given after request from Gosport CID. Not an independent opinion. How did the CPS originally accept it?

Para 1

How is it that my mother's named Consultant Dr LORD was unaware of Lesley HUMPHRIES report for Mr MILLETT, Portsmouth Health Care Trust until her request on the 17 December.

This paragraph is a defence 'Discussions with Philip BEED' and BARTON. 'has not had access to Haslar records'. Surely she should have been aware of the report and complaint before the 17 December 1998 (17/12/1998) when she was the named consultant, in charge of the ward and the complaint concerned two of her own staff, Charge Nurse BEED and Clinical Assistant Dr Jane BARTON. The behaviour of those two members of staff were ultimately under her supervision.

Para 2

No comments on the face on 13/8/98 (13/08/1998) or drugs written upon arrival 11/8/98 (11/08/1998) or BARTON's comments 'quite happy for nursing staff to confirm death'. Obviously in defence of BARTON. I have commented on P30 of 714 rather unresponsive following sedation. LORD should have understood why. I was the daughter present at 1pm (1300). BEED did not give her Oramorph. It was an injection. See my statement and queries when he came in with an injection. Of diamorphine which I would not allow. When he came in again with an injection I assumed it was not diamorphine but I now know you do not inject oramorph. My mother had another injection before going to x-ray.

45mg Oramorph in 24 hour period. Did they raise Yeah. mother to consciousness every 4 hours to giver her oramorph - Rubbish. See my notes P30 of 714. Decision taken for syringe driver on 18.8.98 (18/08/1998) discussion with BEED only. BARTON was not present. We were informed by BEED nothing more could be done and presumably we would want her to have a pain free death. When I said I wanted her back in Haslar I specifically asked BEED if she (my mother) could die in the ambulance. He replied "It is possible". We were given the impression death was imminent and so agreed the syringe driver. My mother was still 'out' from the day before. She did not seem to be in considerable pain, discomfort or distress. The treatment was not reviewed daily. Staff commented that they were surprised she was still alive on the 19th.

Para 3

My mother was not screaming loudly, she was wailing groaning. I have used 'screaming' in my statement but with more experience in the last 6 years I know this is not correct. I have been an emergency patient to A&E after lithotypsy (kidney stone) given pain relief 'Pethodine'. I was moaning but conscious and I sounded like my mother. My mother had been tipped off a sheet onto the right hip. As she could not gain attention to her position I am not surprised she moaned or wailed loudly. See my statement.

Para 4

Yes I agreed to oramorph on the 17 and I assumed that the injection on the 17 was oramorph (I have researched the drugs since). 'A substantive dose a day later' 18.8.98 (18/08/1998). According to the drug chart 18.8.98 (18/08/1998), 10mls 012.30! and 0430. There were no signs of pain and distress, mother was still 'out' from the time she left x-ray on the 17.8.98 (17/08/1998).

Haloperidol had been written up on the 11.8.98 (11/08/1998) but not given by BEED who preferred to keep mother sedated by oramorph. My mother had Haloperidol at the nursing home for a good night's sleep but not this dose. Para 5 The agitation experienced at the nursing home is not surprising, now that I have the full drug records for my mother from Basingstoke onwards I am surprised that she had any brain left at all after psychiatric drug abuse over a long period. What on each was Lesley doing to allow her mother to be dosed with Neueoheptics plus other drugs. I was only aware of drugs at Lee on Solent and I thought she had been on them from Dec/Jan 98. Lesley and the GP never mentioned the various cocktails she had been on/off before. There are notes regarding my objections on medical notes Lee on Solent GP and nursing home records. Inability to communicate - no hearing aid or glasses - I can find no medical record of cataract removal at Moorfields from Basingstoke onwards or at Lee-on-Solent. Side effects of Neueoheptic can cause loss of coherent speech. Dr BANKS comments my mother was allergic to Mellesil and suggests aromatherapy and therapeutic touch

Para 6

Addressing pain anxiety and agitation. I was under the impression it was to give my mother a pain free imminent death.

Para 7

??? care could not be given Gosport medical notes do not confirm - the reverse 'Mrs RICHARDS could not understand' - she was unconscious! Hyrozine would dehydrate all fluids - excretions including the ??? & lungs - also skin. It dries you out. Often in cough mixtures but not at this dose level. My mother was not transferred to Haslar for a surgical procedure - the ??? did not involve surgery. There was no question of a 3rd transfer back Intravenous drip would not have altered the outcome but it would have given a more comfortable death. Dehydration is extremely uncomfortable. See previous BMA and letters to the Times from medical experts will confirm, Jan 6-9 1999 sent to DI MORGAN.

Para 8

No - lack of intravenous drip was not raised by Lesley or myself we were under the impression from BEED mother was about to die on the 18th. We were dismayed that it took 4 days. Lesley's notes were written 4 days before death.

DOCUMENT RECORD PRINT

Dr LORD's opinion continued. Cont

Para 9

1st dose of oramorph was agreed on 17/8/98 (17/08/19998) with me. I thought it was in the injection given by BEED after refusing to let him use diamorphine.

Yes Lesley and I agreed to syringe driver with BEED. See previous comments.

LORD places these discussions fully with BEED. There is no reference to BARTON and general anaesthesia for a haematoma as contained in HUMPHREY's report or as confirmed by BEED to DC MADDISON as per my statement 27.4.99 (27/04/1999) LORD would have known you do not treat a haematoma with surgery or a general anaesthetic - and of course there is no write up on medical notes or evidence of a haematoma. LORD makes no comments in defence of BARTON or BEED.

BARTON, BEED and LORD are all covering for each other. BARTON is guilty of negligence but in my opinion BEED is the worst of the lot.

G M MacKENZIE

P461 of 714

My mother was not admitted on the 17.8.98 (17/08/1998) with a diagnosis of broncopneumonia following broken hip - nor was treatment of syringe driver given on the 20.8.98 (20/08/1998). It was set up on the 18th.

It would have been 'normal' in palliative care for the syringe driver not to have been set up more than 24 hours before death - only as a last resource even in cancer deaths it is not set up until the last few hours which sometimes lasts 24 hours but usually far less. I am not a medical expert but I have witnessed this on several occasions at the Marsden (my husband and other patients) and another hospital in Essex with a cancer patient in the last few hours. They were not kept unconscious for days.

I do not think my mother was anywhere near death on the 17/18.8.98 (17/08/1998) (18/08/1998).

G M MacKENZIE

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Written by P BEED (?) my mother did not arrive on the 11.8.98 (11/08/1998) Gosport with a dislocated hip. Just how careless can BEED be?

G M MacKENZIE

Page 64 of 714

I find it extremely difficult to read the dates but it seems that BEED, JOICE and ??? gave 40mg diamorphine in the syringe driver at ? 1120, 1045 and 1100 and JOICE gave more at 1800, 1800 and 0800, how much?

See note on P.63 of 714?

63 of 714

How much did JOICE administer when she came on and went off duty? Another 40mg or 20mg. Records abysmal. Patient was not drowsy - she was 'out' from 17.8.98 (17/08/1998) after x-ray. She never opened her eyes or stirred.

G M MacKENZIE

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Hyozine given on 18?8.98 400mg by BEED. Hyozine dehydrates. BARTON does not mention it until the 21.8.98 (21/08/1998).

Page 30 of 714

BEED jumped the gun ??? Hyozine given 18 ? 19, 20 before BARTON's instructions. Times of syringe driver (from 18.8.98) (18/08/1998) not correct. Syringe driver times do not coincide with times given on P.63 of 714. I stayed overnight from the 18.8.98 (18/08/19998) onwards. See medical file and Lesley from the 19.8.98 (19/08/1998). She can confirm syringe driver 'replenished' but no note is on file. The times or the amounts given. If BEED gave 40mg in the syringe driver how much did JOICE give at a different time. P.63 of 714.

G M MacKENZIE

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Why did my mother have to undergo an x-ray at Gosport. A GP should be capable of recognising a dislocation. BARTON was on the ward when my mother fell, 13.8.98 (13/08/1998). Why didn't she examine my mother. I understood Karen REED saw my mother in the Day Room shortly after fall discovered. Did she fall in the Day Room? Is that why they did not know how long she had been on the floor. Why was the Day room unsupervised. These are discrepancies here. Why hasn't Karen REED been interviewed and not come forward? Karen REED one of Lesley's daughters and an ex Haslar orthopaedic nurse.

17.8.98 (17/08/1998)

Remained unresponsive for some hours - not surprising with oramorph 11, 12, 13, 14 followed by IV sedation at Haslar.

DOCUMENT RECORD PRINT

"They give oramorph in severe pain". BEED quick off the mark. My mother was not screaming but I think she was in pain groaning/moaning. She had been carried on a sheet from the ambulance - 'tipped' onto the bed onto the right hip. BEED had been informed there was no canvas. A canvas was on the back of the chair in my mother's room. Why didn't BEED ensure that it was used to transfer my mother from the ambulance to the bed. See CHI report and my statement (BALDECCHINO).

18.8.98 (18/08/1998)

"Still in great pain" Rubbish - she never regained consciousness from returning from x-ray approximately 4.30 (1630) 17.8.98 (17/08/1998). My mother was talking to me whilst I accompanied her to x-ray, holding her hand. Lesley was there. She lost consciousness in x-ray. BEED gave her an injection at 1pm (1300) and another just before she went down to x-ray approx 3.45 (1545). You do not inject oramorph. See my statement. I strongly question the drug chart for 17.8.98 (17/08/1998). Mother received nothing after returning from x-ray and Lesley and I did not leave until well after 8.30pm (2030). If mother was given oramorph on the 18th, 2.30am (0230) and 4.30am (0430) did they wake her up to give it to her by mouth? Mother was 'out' when we arrived on the 18.8.98 (18/08/1998) shortly after 9am (0900) on the 18/8/98 (18/09/1998) when we were interviewed by BEED alone.

G M MacKENZIE

Page 29 of 714

Drugs written up without proper assessment - see REID's letter - Haslar staff statements - Haslar file - my mother was transferred to Gosport "for 2-4 weeks" to give Lesley time to find a suitable nursing home on discharge. See Haslar file notes.

BARTON notes 11.8.98 (11/08/1998) "Not obviously in pain". Why did BEED administer oramorph?

14.8.98 (14/08/1998) 'Fell out of chair last night' who told her (BARTON) that? She fell at 1330 previous day. See Gosport file.

My mother did not need a further surgical procedure. BARTON seems incapable of assessing the x-ray. It is not up to her to comment.

BARTON is convinced my mother is about to die. Drugs appropriate for palliative care (last stages). I am not a medical expert but I did spend the best part of 2 years in (living there everyday) at the Royal Marsden, I was aware of the palliative care drugs for my husband and these were discussed fully with my husband and myself. I have also had experience as a volunteer "gofor" with the local hospices.

G M MacKENZIE

Page 22 of 714

This is not correct (see drug chart).

DOCUMENT RECORD PRINT

Oramorph given by Philip BEED 11 August shortly after admission x 2 plus 12 13 14 August. Lesley LACK informed me that she had complained on the 12.8.98 (12/08/1998) and mother was taken off it - she was not.

What time did my mother arrive at Gosport - I understood she was accompanied by Lesley. There was some haste to commence oramorph despite the fact that the letter from Haslar, 10th august (typed up on the evening before discharge from Haslar) states painkiller PRN Cocodomol. Has a Detective checked the Haslar file which was missing from the papers sent to FORREST? (Do I have to act as 'law expert' and Detective.

See also BARTON's comments 14.8.98 (14/08/1998) very sensitive to oramorph. Mother was 'out for the count'. Page 29 of 714.

Oramorph written up by BARTON 11.8.98 (11/08/1998). BEED quick off the mark. CHI report "No pain assessment procedures in places".

If my mother was 'very sensitive to oramorph' why didn't BEED query and cease the dose?

Pain was not a problem - BEED does not know or choose to know the wailing of a dementia patient and a scream.

Lesley will confirm and the nursing home notes confirm wailing.

G M MacKENZIE

General Medical Council

Dr. Jane Barton

Exhibit GM/8A

This is the Exhibit marked "GM/8A" referred to in the statement of Gillian McKenzie:-

- original notes and comments which formed complaint/questions to the Trust in my sister's handwriting but jointly compiled by us both

(1)

Ref Gladys Richards DOB **Code A**

No analgesia received

Tuesday 11th Aug. Admitted from Hasler. Ambulant Pain free
Wed. 12. Generally unwell. Oramorph given (Knocked off) so no fluids could be given. Thought her drowsiness was Pain.

THURSday 13 Aug.

Seen to be in pain by Grandaughter. HRS Reed 1.30 - 2.15
Brought to ward staffs attention. Thought to be dementia related
Mother showing with pain to ward that Mum had great pain in hip. Forgot
HRS Read brought to the attention of the staff before she left
info HRS Read is a qualified Nurse Pr.

(1) At what time did HRS Richards fall?
(2) Who attended to her.
(3) who moved her and how.
(4) 3.45 - 4pm I arrived and saw my mother was in pain. Anxious expression, weeping - calling out. I spoke to several trained and untrained staff. I was told - there is nothing wrong - its her dementia A I asked had she seen a Doctor? Could she be Xrayed? At supper time while my mother was quiet and I was teaspooning her some soup I was asked "Do you think your Mother is in pain?" by RGN doing the drug round. "Not at the moment while I'm feeding her?" I said "Well you said she was in pain". "Yes" I said "she has been very uncomfortable since I got here". "Do you think she has done some damage?" "No" "she only fell on her bottom from the chair" I stayed till 7.45pm My mother was in great distress throgout.
I was then told she had fallen from her chair.

At 9.30pm. I received a phone call from the ward. "When we put your Mother to bed she was in great pain and she may have done something. The Doctor feels its too late to send her to Hasler and our Xray unit is closed. We will give her oramorph for the night to keep her pain free and Xray here in the morning."

(5) This was an avoidable delay. Why? Any lay person could have seen she was hurt by the angle of her thigh & leg

FRIDAY 14th. I arrived as she was taken to Xray

Daedelas.

(2)

She was deeply under with oramorph.
She was xrayed. The movement caused pain, and I stayed with her to comfort her.
We returned to the ward. I was called in to the office by Philip - ward manager and DR Barton to be told - "Your worst fears of last night appear to be true. We have rung Hasler and they have accepted her back."
We arrived at Hasler late morning - mid day. She was expected. The consultant was bleeped. He saw Mother in Casualty immediatly. He then saw me. He showed me the Xrays and position of limb - which I had seen in G.W.H
24 hrs from accident to admission and second emergency operation. Why? why no examination? why
(6) no xray? why no transfer?
She arrived at Hasler and within 1hr had a manipulation to put the hip back in the socket. From then she was pain free.
She did not regain consciousness fm 1am (15th) on Sat 15th due to amount of analgesia required for the procedure. She was then catheterised so that there was no need to use slippi pan. She had a drip as she had had NIL BY MOUTH since before Xrays on 14th.
She remained pain free in full length leg splint. both legs level and straight - shown to me by consultant. No analgesia was required - she was able to use a commode for the toilet and weight bearing for transfer. She ate and drank and the drip was removed and her fluid balance was acceptable.
She progressed on Sunday and was easily manageable. She was seen early a Monday 17th when transfer back was recommended. I rang Hasler at 8.30am to be told she would be going A.M. I asked if I should come & pack & accompany her and they said "No nee

(3)

She is fine". I went to G.W.H about 10.45am and was told the ambulance was due about midday. I arrived back. at 12.15 mid day
On entering through the swing doors to the ward I heard my Mother screaming. On arrival to the room a care assistant said "You try feeding her I can't do it she is screaming all the time". My Mother had a starving anxious expression. She was gripping her Rt thigh op site 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 sharp sharp. — this is some adventure. A SRN came into the room at all the noise I moved the sheet and said look at the awful position she is in, she was lying awkwardly towards the left side with the full length splint not straight and the hips uneven. She cried in pain. I said to the RGN "can we please move her" We moved her together with our arms together under her lower back and the other around her thighs we placed her squarely on her buttocks and within minutes she stopped the screaming.

(7) Why when returned to bed from the ambulance was her position not checked.?
why was the source of pain not sought?
From 1pm onwards the Charge Nurse Manager frequently checked my Mother. He acknowledged our concern. He acknowledged her obvious pain. We asked for X rays We asked what had happened between leaving Hasler & arrival into her bed at G.W.H. It was acknowleged that "Something" had happened

(4)

The charge nurse was concerned for her pain and analgesia was given 3 times between her admission & 6pm.

Phillip's ward manager agreed she needed Xray to establish if damage had been done as had occurred to the hip.

Xray Dept refused forms signed PP for the DR who was unavailable

An appointment for Xray was made for 3.45pm as the DR called was expected at about 3.15pm The charge Nurse did all he could to expidite this - keeping us informed and constantly checking Mothers obvious severe pain. He administered pain relief in readiness for the Xrays. He was courteous and attentive at all times.

DR Barton arrived and we left the room as asked She examined my Mother. She stated she did not think there was further dislocation but the Xray would go ahead. A review would be held later when Xrays had been seen.

We went to Xray. My mother was in pain despite her pain relief. I was not allowed in with her as I was the previous week. I could hear her wailing through the doors while the Xray plates were put in place. We returned to the ward. We were told there was no dislocation but obviously something had happened. We were told she would be given Oramorph for the pain & help through the night for pain relief and reviewed in the morning.

On Tues 18 we arrived on the ward and were told she had had a peaceful night We were told that she had a massive haematoma causing pain at the Op site

(5)

and the plan of management was to use a syringe driver to ensure she was pain free and she would not suffer when she was washed - moved or changed should all become inconvenient.

The outcome of the use of a syringe driver was explained to us fully. We agreed.

A little later DR Barton appeared and confirmed that a haematoma was present and that this was the kindest way to treat her. She also stated "and the next thing will be a chest infection". Totally insensitive to those already in the first stages of bereavement. Because the syringe driver was essential following the administration of analgesics for pain - my mother of course would not now regain consciousness, speak, open her eyes to see us, or hear anything anymore. To us Mother as we know her is already gone.

(8) How was she brought from Hastar? Was there an escort? Was anyone in the back with her? When did she start to show pain? What caused it? (9) I request again that see the last X-rays upon decision were made to do nothing but allow to die pe

Answers to the numbered questions are sought in fr detail (1-9) please.

Trivial things added to our trauma. Her clothing already each's name tabs marked. — had all gone the day after 1st admission for marking - despite my agreeing to do the washing daily. So she wore other peoples clothing from then on (8 days)

Asking continually, to insisting today that Mother be allowed to wear her own clothes has resulted in them being brought by Taxi from SV Mays 8 days later - still unmarked and all totally unnecessary. — as was a staff Nurse yesterday asking to take her day clothes away - "because we get them up her you know". Our reply was - Just look at her - she will not be getting up anywhere.

The contents and events in this report were in the majority witnessed by my elder sister Mrs Mackenzie.

Code A

* It should be noted that on Monday 17th I left my sister at G.W.H. and went to Hasler about lunchtime. I was so appalled at my Mothers condition discomfort and severe pain. I went to the ward E3 and asked how my Mother was when she had left the ward. I asked because when I had spoken to the ward on the phone that morning they said the consultant was happy to send her back to G.W.H. She was eating, drinking, using commode and able to stand if aided. This was Monday 17th am On leaving the ward I bumped into the DR who had been in Casualty Theatre for my Mothers second operation. He was with the Consultant when all the procedures were explained to me on Friday 14th. He said 'How's your Mother' I explained in detail. He said We've had no referral. Get them to refer he back we'll see her. ~~I said I had [illegible] I would be [illegible]~~ I told him she was in severe pain since the transfer.

General Medical Council

Dr. Jane Barton

Exhibit GM/8B

This is the Exhibit marked "GM/8B" referred to in the statement of Gillian McKenzie:-

- police document containing (in typed text) our questions/comments and the Trust's response – with handwritten annotations by me with my response/comments (as requested by police)

HAMPSHIRE CONSTABULARY

C.51 4/96

Identification Ref. No. GM/1

Court Exhibit No.

R - v -

Description

Copy of Hand-Written Notes

Time / Date Seized / Produced

Where Seized / Produced

Seized / Produced by

Signed **Code A**

Incident/Crime No.

Major Incident Item No. 219

Laboratory Ref:

COMPLAINT MADE BY MRS. L. LOCK RE. STANDARDS OF CARE FOR HER LATE MOTHER MRS. GLADYS RICHARDS WHILST A PATIENT ON DAEDALUS WARD - G.W.M.H FROM 11.08.98. TO 14.08.98. AND 17.08.98. TO 21.08.98.

1. At what time did Mrs. RICHARDS fall?

Answer - 1330 hours on 13.08.98.
This is in conflict with the medical records - no definite time could be given. There was the string - in the room or in the patients lounge. The room with a glass window and the corridor should have meant immediate attention. The room was opposite the reception / Nursing desk.

2. Who attended to her?

Answer - S/N Jenny BREWER and H.C.S.W. COOK
If Dr. Dallas was in the hospital at the time? The fore why didn't She examine my mother.

3. Who moved her and how?

Answer - S/N Jenny BREWER and H.C.S.W. COOK using a hoist.
A fore been a clear after a hip operation (new hip) should have had to a thorough examination (without clothes) in a prone position.

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

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

Mrs Lack informed me she had spoken to several 'nurses' and Mrs Karen Reed who saw my mother shortly after fall (she was not informed that) also spoke to Scott. I was not in Egypt at time / that but have since heard Scott (Nursing Staff) say ~~she~~ Mrs Lack had my mother cries not due to dementia. Queried medication because when 24hrs of admission my mother was so 'zonked out' rehabilitation is working

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

See attached sheet.

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

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

I understand Mrs Lack was informed by telephone at night. No doubt she was in an extremely upset state at the time & back the Doctor's advice. She telephoned me & was very upset at the time

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

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

Not acceptable. Mrs Richards diagnosis prior to fall in hospital despite her age was that she was healthy enough to be considered for rehabilitation at Dr at Haslar to be considered for rehabilitation at Dr. at Haslar report) Oramorphine was strong enough to make Mrs Richards obvious ? Cannot to transfer to Haslar. Inquest ? stated privy did my expert my mother to die in the night at Gosport which would answered questions being asked?

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

X-ray could have been carried out between 1330 & 5pm close to the quiet duties performed by my mother & witnessed by Mrs K Reed & Mrs Lack

Why no transfer?
As above.

I fail to understand why trauma in transfer to Haslar at night would have been any greater than trauma the next morning. Except it was probably more 'convenient' for staff at G.W.M.H irrespective of duty of care to the patient & the possibility that the fall trauma & pain could have further hastened her death before the morning.

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

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

I believe the HCSW was Linda - who was since 'discussed' the situation with me. The trained Nurse obviously took no notice of the request - it was only after my arrival when this took at approx 12.20 hrs that I asked the Nursing attendant, who was attempting to feed Linda to my Mother, to get a qualified Nurse. I then pulled back the sheet & saw my Mother's position in the bed. She was lying on the injured hip.

8 (a) How was Mrs. RICHARDS brought from Haslar Hospital? This turned out to be on a sheet not a stretcher

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

We already knew she came by ambulance & we had suggested that she should be accompanied by her bed. I heard the telephone call to Haslar bec we were informed it was not necessary. She was obviously considered fit enough by Haslar. There were witnesses in Haslar (ward) who saw my Mother leave the ward perfectly alright. I was informed of this by the ward

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

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

(c) Request to see x-rays denied?

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

Mrs Lack did not originally ask to see the x-rays with ward staff. I witnessed her ask staff in the X-ray department. The Doctor + Consultant Radiologist could have told us the result of the X-ray then. It had nothing to do with the ward staff.

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

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

This is totally incorrect. My sister and I saw Dr. Barton together on the Monday evening only because I saw her pass my Mother's room + we both went out into the corridor to speak to her. We were not told then of the haematoma. Dr. Barton said a decision could be made in the morning & she was upset by Mrs Lack that Heaven would have her back. Steenjet away.

TRIVIAL CONCERNS RE CLOTHING/LAUNDRY

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

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

This does not make sense. All my mothers clothes were marked as she had been in a Nursing home before hospitalisation. My sister visited everyday & did her laundry there in Harlow and ironed and then she told do the same at Egspar There was no need to re-mark same. My mother was in a single room.

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

A taxi was authorised after I had made my feelings known & my sister had volunteered to send a taxi at her own expense. At first we were told that the clothes would be back in a day or two & I informed the receptionist my mother was dying now.

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

I would find it difficult to believe as well but it did happen

ANALYSIS OF EVENTS

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

See letter from Haslar to Road. She considered she was fit enough for rehabilitation. When she was confused I could allege this was not helped by the drugs given.

On arrival to Daedalus Ward, Mrs. RICHARDS was quiet and accompanied by her daughter, Mrs. LACK. She was admitted by Enrolled Nurse PULFORD and Mrs. LACK was seen and told of the plan for managing her mother whilst on Daedalus. Mrs. RICHARDS was also seen by Dr. BARTON and medication was prescribed. I understand Mrs Lack emphasised that medication which 'Zonked her out' did not aid rehabilitation nor did it enable her to eat or drink. After Haslar Hospital her head balance was not right on return to Haslar after the fall. 2-3 days later

Wednesday 12th August, 1998

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

Mrs Richards was already been lifted from the face by hoist. Miss Karen Reed had been concerned at Mrs Richards tiredness when she seen her in the afternoon + reported it. She was not informed of the face. Mrs Lack on being informed by Miss Reed visited her on mother She was not informed of the face only later after feeding supper.

Thursday, a.m. 13th August, 1998

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

How long did my mother lay on the floor while she was found at 13.30 + where was she found.

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

At what time did Mrs Richards have lunch + who fed her (Staff shortages.) Since when is a Nurse qualified to examine a fully clothed hip when no radiologists were daily their wards. Did she supervise the lying or merely authorise it.

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

Mrs Reed had visited my mother in the afternoon Mrs Reed is an ex Harlan Nurse (orthopedic ward) why wasn't she informed of the fall. She was aware of my mothers distress & informed Nursing staff.

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

Mrs Richards was lying on the floor after the fall - why did it take so long to a proper examination? Why didn't Dr Barton examine her as the Consultants round at 2pm

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

Mrs Lack can answer this better than I can when my sister telephoned me she was very upset but in a way relieved that at least my mothers pain was recognised + not merely pushed aside as Dementia

Friday 8.00 a.m. 14th August, 1998

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

Monday 11.45 a.m. 17th August, 1998

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

Screaming. When we arrived at 12.15 She was screaming & continued to do so until after we had left despite pain medication. She was conscious & continually told me to do something' even when I held her hand as we went down to X-ray department

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

This is not correct. There was no pillow between her legs when Mrs Lack & myself arrived at 12.15 & the pillow was only placed here on my Sister's instruction to the Nurse (Couchman). HCSW Baldacchino is 'Linda' previously referred to by me.

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

Not correct. We requested x-ray. Philip was the Nurse concerned. He informed us his signature had not been accepted & he was unable to contact a Doctor as there was a meeting going on. He later informed us Dr. Barton was due on about 3.30. Dr. Barton then examined my Mother & agreed an X-ray

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

Not correct. See previous paragraphs.

After the X-ray & my conversation with Philip he later came into the room (my sister was present to give diamorphine. I objected strongly & said I would not agree to diamorphine until a decision had been made the following morning. I said & I quote. 'Are we talking about someone's

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

Cont:

she felt her mother was on her bed too much and this would not help with rehabilitation. This was when she was 'sailed out'
During her last day of life Nursing Staff were prevented from removing Mrs. RICHARDS' dentures as part of mouth care as the daughters said they were not to remove them.
I am at a loss at these comments. I was unaware that I did not agree with my sister regarding my mothers care particularly about pain control. We were both fully in agreement that the Nursing care be left as it had to be dressed I was not at hospital at the time of my mothers fall so I had no connection with making the Nursing of Mrs Richards deficient. at times or the diaper given

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

Why? see additional note.

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

We were "courteously" with my Mother night & day. I slept here by her bedside from Tuesday night until she died on Friday. Nursing staff were not obtrusive but there a pity communication was so poor that a Kiwi an orderly had to find me why I had not taken Zopiclone at the trolley although the curtain was drawn & he door closed I

CONCLUSION

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

why wasn't there a witness - with a window into the corridor & her door open - opposite the desk. The Nursing Staff had been warned that my mother would attempt to walk to the lavatory & she could not get assistance - why wasn't a table put in front of her from the outset. It is obvious that patient care did suffer.

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

See previous comments. no examination on the floor or other inadequate examination

When did dislocation occur, i.e. when she fell? Or when hoist was used? - unable to define. Pretty obvious when she fell & made worse by the hoist. A hoist was used on many Once x-rays confirmed dislocation, transfer to Accident and Emergency at Haslar was arranged - as appropriate.

occasions at Haslar - it did not dislocate the new hip

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

I agree with this, a Mrs Richards walked up with Paramedics would not have been aware of the time.

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

Why did Gosport accept Mrs Richards on Carwar. She left Ne ward at Haslar pain free. She should have been sent back to Haslar immediately.

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

It was noted by Mrs. Hack + myself the Nurse came after we demanded it. If she came at Baddaelunck enquiry prior to our arrival she did nothing. When she did come at approx 12.20 my Sister instructed her + helped change my Mothers position with a pillow between her legs.

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

Unacceptable a conflicting We were not told after he had only left morning by Philip we were informed nothing could be done & ~~death~~ he imprisoned given that death was imminent.

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

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

RECOMMENDED ACTION PLAN (to be agreed with Service Manager)

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

2. Review nursing records and documentation.

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

4. Review marking of clothing "policy".

X 1. This clearly indicates that it was "policy" not to transfer patients outside working hours + had nothing to do with the trauma my mother might have encountered by Dr. Barker & the Nursing staff on more than one occasion.

2. Nursing & medical records were examined.

Additional notes.

Complaint questions & answers Parliament Health Authority.

4. Cont. Page 2

Page 2 walking was a runner was impossible. His both informed me on the telephone she had queried to the strong medication which was not given during my Mother's stay in Hospital No pain killer medication or tranquilisers were being administered when she was referred to Gosport War Memorial Hospital from Hasler

5. As far as I am aware 'full details' were not Page 2. given to His both. I am of the opinion this both would have queried the non-examination by Dr. Barton

4 Cont.

Page 4. When he enquired Nurse answered we pulled both the sheet. The Nurse + His both moved my Mother. I asked the Nurse how had my Mother been separated from the stretcher to the bed. It looked as if she had been rolled off the stretcher onto the bed. Had the bed been moved from the wall to accommodate the procedure with a 'Nurse' each side? She said she did not know. By his tone she would certainly have known not a stretcher had not been used. She certainly had not examined my Mother's position before she began. If she had done so she did not do anything about it.

8b. The cause of pain cannot be confirmed. We Page 4. knew she subsequently had a haematoma at site Her leg was in a canvas splint. After my Mother was X-rayed I asked Philip Leslie her

8b. Page 4

pain have been caused by the stitches ie. the pates inserted down the side of the canules - when they were inserted or removed. He (quite defensively) stated "I should think that was unlikely" At the time he knew the result of the X-ray (a massive haemorrhage) but he only said to me "he will be released to Rum she has not dislocated her hip again - perhaps she has sprained a bit of bruising" He also knew that a canules had not been used. He quite deliberately did not give me a straight answer. I only knew of the massive haemorrhage the next morning. Nor did Dr Barton mention it when she told Mrs Lamb & myself that a decision would be made next morning. Is this another situation when it was thought unwise for Mrs Richards to possibly die in the night at Eastpoint rather than transfer her to Hereford again when surely Hereford staff would have asked questions. Hereford had already agreed with my sister that my mother could be transferred to them again.

8 d.

Dr. Barton stated that she thought it would be too much for my mother to return to Hereford that evening but that I should & myself should return to Eastpoint next morning when the situation would be discussed. This we did but we did not see Dr. Barton on answer - see Sec Rep.

Ed. Cont.

P. 5.

who informed us nothing could be done for her massive haematoma except a pain free death with the aid of a diamorphine syringe. No mention was made of surgery. When the question of general anaesthetic been mentioned I could have pointed out that the hip replacement and later re-location had been carried out without general anaesthetic. I could have argued if simpler procedures could have been carried out for the surgical procedure!

Mrs Lacey, Mrs Rebecca (?) + her baby (Neil) + myself were all present in my locum's room after he setting up of the syringe by Philip when Dr. Barton came to the doorway. She said ~~a report~~ "I understand the situation". He stated that the diamorphine has been explained to us" Dr Barton then said "the reason the next step will be a chest infection" Mrs Lacey + myself explained — although at the time I thought she was referring to 'dead mans rattle'. She made a few comments about the baby. We did not see Dr. Barton again.

8d.

P. 5 After my mothers death & the Health Visitor had been sent for Couplands procedure to begin I had telephoned Mrs Holeman Sam (?) Humphreys (Cot. St James) and asked for the additional question to be added. ie. why wasn't a drip put up? I was informed on the telephone that it would have been explained to me by Dr. Barran I confirmed that it had not. I believe there is some query now as to whether Mr & Mrs H was consulted to do so.

At the time we were informed by Philip that nothing could be done I was extremely under the impression that death would be quite soon. Had I known that my mothers heart was strong enough to endure constant diamorphine & dehydration for 5 days I would have not accepted that she was anywhere near the terminal stages of dying. Obviously she wasn't. Anyone dehydrated for 5 days on a diet of diamorphine only would not have survived very long.

Analysis of events Pages 7-17.

Page 12

because I were not agree to euthanasia"
Phelp then left the room & came back
with an alternative pain Killer.

Page 13

I am appalled at the comments regarding
mouth care. We were present when a Nurse
tried to take out my mothers dentures
without success. My sister then tried & my
Mother bit her! This may have been just a
reflex action but it extremely did not take
place on the last day of her life. At the time
of the 'biting' my sister did say 'leave
them in' as it seemed to us pointless to
distress my mother further.
If my mother was so close to dying I
fail to understand why it was "in her best
interests to have her teeth cleaned."

Page 13

I told the Kitchen orderly to get out as
my Mother was dying (about 7.pm) & she
then proceeded to tell me I would have
to have supper as I had paid for it. I was
not perturbed worrying what I said but she did
leave the room.

Code A

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General Medical Council

Dr Jane Barton

Statement of Lesley Frances O'Brien

I, **Lesley Frances O'Brien**, will say as follows:

1. I make this statement with regard to the treatment of my mother, Gladys Richards, who was born on 13 April 1907 and died on 21 August 1998 whilst a patient at the Gosport War Memorial Hospital ("GWMH").

2. My maiden name was Lesley Richards and I was also previously known as Lesley Lack. I have however since remarried and am now Lesley O'Brien.

3. Exhibited to this statement and marked "**LOB/1**" is a copy of the statement which I made to Hampshire Police dated 31 January 2000 with regard to the treatment of my late mother.

4. I made a further statement to the police dated 11 August 2004. Exhibited to this statement and marked "**LOB/2**" is a copy of my statement of 11 August 2004.

5. I confirm that I have had the opportunity to re-read my witness statements made to Hampshire Police and would like to make the following observations and amendments and also to exhibit further information.

6. I am a retired Registered General Nurse. I retired in 1996 after 41 years working in the nursing profession. For 25 years prior to my retirement I was involved in the care of elderly people in supervisory, advisory and management positions.

7. My mother, in her younger days, was generally fit. She was widowed at aged 67 and from 1984 she lived with me. I am her second daughter and we were very close. She enjoyed very good health and was very independent. As time went by it became apparent that she could not cope at home whilst I was at work. She would forget to light the gas or go for a walk and forget the key. At the time I was running a nursing home in Basingstoke.

8. I would say that in her 80s my mother got more forgetful. She would eat with me at the dinner table and could have a normal conversation with me but did not have very good short-term recall. I therefore asked if she could be admitted to the home where I was working. This was called Ashcombe House in Basingstoke. My mother therefore came to live there.

9. This arrangement worked really well and was a superb situation for me. My mother had a nice room and because I worked at the home it meant that I could see her every day.

10. I would describe my mother as being pleasantly confused. She was not aggressive or nasty in any way. Sometimes she would say to me "Gill, I haven't seen Lesley". This was the wrong way round as Gill is my sister. I would take her home to stay with me at weekends sometimes and she was an avid scrabble player and enjoyed a game of cards.

11. I would say that my mother was in the nursing home for about three to four years in Basingstoke and during that time my sister, Gillian McKenzie, probably visited her twice.

12. I think that my mother had started with dementia. She never saw a psych said that she had Alzheimer's. My mother was a lovely lady and sl physically ill. I would say that she was about a size 14-16 dress size. Wi in the home in Basingstoke she enjoyed playing cards, joining in the te quiz games. At no time was she considered to be frail.

13. In 1997 I was thinking about retiring. Three of my daughters lived in Hampshire, in the New Forest and two in Gosport. I decided before I retired that I wanted to move my mother to the seaside. My eldest daughter Karen Read is also a nurse. Karen knew a nurse at a home in Lee-on-Solent. The home was brand new and there was a room free for my mother. The home was called the Glen Heathers Nursing & Residential Home in Lee-on-Solent, Hampshire.

14. I explained to mum that I was retiring to the seaside and she moved down to Glen Heathers approximately four to five months before I sold my house in Basingstoke.

15. Whilst my mum was in Glen Heathers my eldest daughter, Karen Read, who is the nurse, visited her every other day and used to do her hair and nails. I used to visit mum at the weekend. Sometimes my mum did not realise that a week had gone by since I last saw her.

16. Whilst my mum was in Glen Heathers they increased the drugs that she was on. She was not as bright and cheerful as she had been previously. I did question why she was on more drugs with her GP. Her GP told me that the nursing home had requested more drugs to keep the patients manageable. This went against the grain of everything I had put into practise whilst I was a nurse, and in charge of the nursing care of elderly people.

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12. I think that my mother had started with dementia. She never saw a psychiatrist who said that she had Alzheimer's. My mother was a lovely lady and she was not physically ill. I would say that she was about a size 14-16 dress size. While she was in the home in Basingstoke she enjoyed playing cards, joining in the tea dance and quiz games. At no time was she considered to be frail.

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17. My mother would still read a daily paper every day and was still very communicative but due to the drugs she was on was not as bright and cheerful as she had previously been.

18. For my mother's birthday celebrations we always had a little party wherever she was. We had a party for her birthday every year from when she was 80. I would always take a cake. I have a big family and we would all go and see her. Grandchildren and great grandchildren and she always enjoyed the company. Her last birthday celebrated her 92nd.

19. Exhibited to this statement and marked "**LOB/3**" is a copy of photographs taken of my mother at her 90th birthday party.

20. Whilst my mother was at Glen Heathers she had a series of falls. Then on 29 July 2000 mum had a fall and it transpired that she had broken her hip. There was some problem with the care that she received in the nursing home as they were slow to react to the situation. In the end the home telephoned me and said that my mother was going to be admitted to the Royal Haslar Hospital by ambulance. I went and met the ambulance at the Royal Haslar Hospital.

21. My mother was admitted into Haslar on 29 July 1998. Initially the hospital was not sure if my mother would survive the night as she was very poorly. She was in a lot of pain as the sharp edges of the broken bone at the top of her hip were pushing into her muscle. This was shown by the x-rays.

22. My daughter Karen joined me at Haslar Hospital. My mother had been given morphine and I was told that a decision would be made the next day about whether or not to operate. I also met with the consultant.

23. Prior to this fall my mum had still been mobile. She used to go for walks around the home and outings to the seaside. The consultant therefore said that it was worth doing the operation. We did say that if my mum's health failed on the operating table then she should not be resuscitated. However, much to our surprise and delight, my mother came through the operation fine.

24. My mother made an amazing recovery after the operation. She was on sedatives immediately after the operation but within 48 hours of the operation she was much brighter and was up on her feet, walking with a zimmer frame and doing exercises. She was compos mentis and recognised myself and her grand-daughter. She was making a fantastic recovery. My mum had been eating three meals a day while she was in Haslar Hospital and I would describe her as being quite robust.

25. Subsequently to my mother's death I had an opportunity to examine the medical records and noted that whilst she was at the Royal Haslar Hospital the fluid balance chart documents that she was eating properly.

26. Exhibited to this statement and marked "**LOB/5**" is a copy of the fluid balance charts.

27. I visited my mum in the Royal Haslar Hospital every day. She was capable of asking for food. I used to take her in little treats like a Marks & Spencer lemon mousse or a portion of strawberries and cream. I felt that my mother was very much back to her old self. For example, she made some comments about a cleaner that was working in the ward.

28. My mother had no problem with her wound site post operatively. She could also go to the toilet with assistance.

29. My sister, Gillian McKenzie, came down when mum had the operation. Gill arrived when mum was in theatre and then stayed at my house for the next two to three days.

30. Whilst mum was at the Royal Haslar Hospital she was not having any pain relief, just the odd paracetamol.

31. My mother was then transferred from Haslar to the GWMH. I was told at Haslar that they could only keep mum for so long in order for her to convalesce. She was only in there for 11 days which is not very long. Before my mum was moved to GWMH I went to visit the hospital with my sister Gillian. The staff showed me a four-bedded ward and I thought it would be fine. They said that once she had been admitted it was probably best not to come for a little while in order to let her settle in. My mum was then transferred from Haslar to GWMH on 11 August 1998. I went on the next day to see her.

32. When I got to the hospital to see her she was in a single room on the left-hand side of the corridor. The room had glass windows and the curtain was drawn. I was very surprised to find that mum was not rouseable. Her eyes were closed and I would describe her as being "out of it". I went to find a nurse to find out what they had given to her. This was a huge contrast to how she had been at Haslar where she was having no analgesia and could walk around pain free.

33. I found a care assistant who used to work both at GWMH and also at Glen Heathers Nursing Home. I am afraid that I cannot remember her name given the passage of time. She said to me that mum had been given Oramorph as she was in pain. I explained to the staff that if my mother needed the toilet then she would become agitated. She would be unable to get the words out that she needed the toilet and

would make small noises and wriggle around a bit. Her needs should be foreseen and the question asked "Do you need the toilet?"

34. On 12 August 1998 I stayed with mum. As she had been given Oramorph she was not able to have any food or any drink. Up until her transfer on 11 August 1998 she had been having three meals a day.

35. On 13 August 2008 I had the "day off". My daughter Karen went to visit mum on my behalf. Karen told me that when she arrived mum was shouting with pain and she called the ward staff who told Karen that my mum had dementia. Apparently my mum had a horrible anxious expression and was weeping. This was very unlike mum as she never cried and she was also groaning. The hospital staff said that there was nothing wrong and it was just dementia. I was telephoned at home at 9.30 on 13 August by one of the nurses. They said that they thought that my mother might have done something but they would look into it in the morning.

36. On 14 August 2008 I went to GWMH in the early morning at around 10 am. My mother was completely out of it. Her eyes were closed and I could not rouse her. I went with her to the x-ray. Sliding the plate underneath my mother caused her pain. I was allowed to accompany into the x-ray room and they gave me an apron. My mum was then taken back to the ward. On page 9 of my statement of 31 January 2000 (**LOB/1**) at paragraph 7 I explained that once my mother had been x-rayed I was called into an office by Philip Beed, the Ward Manager who was accompanied by Dr Barton. I cannot remember now whether it was Dr Barton or Philip that said "Your worst fears of last night appear to be true and we have rung Haslar and they have accepted her back".

37. My mum was therefore transferred back to Haslar Hospital. Mother went in the ambulance and I drove to Haslar. The consultant came straightaway to the A&E Department. He was a very nice man and showed me the position of mum's leg and explained what they would do with no delay.

38. She was admitted to Haslar for a second emergency operation and this was done within an hour. The staff at Haslar said that mum could go back to GWMH. I said "Please no" or words to that effect and the consultant said that they would keep her in Haslar for a couple more days.

39. For two and a half days, whilst in Haslar, my mum again made tremendous progress. She had a full leg splint. She was on a drip at first and then was eating and drinking. She was pain free and not having any analgesia. The consultant pulled back the bedclothes and showed me the position of her leg and hip. Mum did not need any injections of morphine and could weight bear and transfer and use a commode. The Haslar staff took her drip down and she was easily manageable. Mum could chat. I

had a friend at the time who also had a relative on the ward in Haslar and she said to me that my mum kept on talking even after I had gone home.

40. On 17 August 1998 mum was transferred back to GWMH. Haslar said that she was fit to do so. I did not really like the idea at the time and I raised my concerns.

41. My sister and I arrived at GWMH and the minute we arrived we could hear terrible screaming. I knew instantly that it was my mum. I can picture very clearly in my mind my mum saying "The pain, the pain". I was so shocked that I left my sister Gill in the hospital with mum and went back to the Haslar Hospital to see what state she had been in when they transferred her.

42. Subsequently I found out that my mum had been transferred from the ambulance into the GWMH ward on a sheet. When I came back to the GWMH I helped to place my mum squarely on the bed and she then stopped screaming.

43. Philip Beed was coming in and out of the room. I found Philip to be quite nice at the time and did not find him objectionable. It was only in retrospect after he had completed reports that I was not happy with him.

44. On page 12 of my statement of 31 January 2000 at paragraph 8 I referred to "a charge nurse". By the charge nurse I mean Philip Beed. That is how we would traditionally refer to male nurses.

45. At this point my mother could still swallow and the pain relief she was administered was Oramorph.

46. Dr Barton then arrived. This is the second time that I had seen her in my mother's room although I had seen her in the corridor at other times. Despite my mother having being given Oramorph she was still in pain and screaming. I was in a panic and kept asking questions. I told Dr Barton that I had spoken to the consultant at Haslar Hospital and they had said to me that they would happily have her back. Dr Barton said that was not appropriate. She said she did not think it was appropriate for an old lady in my mother's condition to be moved again and that they would keep her pain free and review her again in the morning.

47. Further x-rays were taken but I was not allowed to accompany my mother and I never saw the x-rays afterwards. I do not know what time of day the x-rays were taken. I was with my mother all day except for when I went up to the Haslar Hospital for about half and hour. When I was not with my mother my sister would be.

48. I did not stay overnight with mother on 17 August. From 18 August 1998 onwards Gill and I stayed and slept in mum's room. We took it in turns to relieve each other so that she was never left alone.

49. On page 13 of my statement of 31 January 2000 I refer to a conversation with Philip Beed. He told myself and my sister that mum had a massive haematoma. From my nursing experience I would expect some discoloration of the site if there was a massive haematoma and that the wound site would be hot to touch and the patient would show signs of a temperature. I know that from my nursing experience. However my mum's wound site was lovely. I think that she had some internal damage at the neck of the femur which did not show on the x-ray. In GWMH mum did not have a full length splint which the consultant said that she should have.

50. I went into an office with Philip and my sister. He said that it will be easier for the nurses to wash my mother and to change her and move her because the morphine would help her with the pain. He also said that they were not looking for the source of the pain. Gill said "So you will use a form of euthanasia?". I said "I just want her to be pain free". They refused to take her to Haslar Hospital.

51. At the time I was aware, from my nursing experience, what a syringe driver does.

52. Later in the day on 18 August Dr Barton came into my mother's room. I describe this incident at the top of page 14 of my statement of 31 January 2000. Dr Barton stood in the doorway and looked at my mother with her arms folded. There were absolutely no niceties. She said "Well, the next thing you know will be a chest infection". I looked at Dr Barton and thought "My mother doesn't have a chest infection now". Then Dr Barton just left without anyone saying anything more. The syringe driver had been started before we got there on 18 August as we were told by staff that this would be the best way of managing my mother's care. We were not asked to consent to the commencement of this treatment.

53. I feel that I was denied the right to say goodbye to my mother. Once she was on a syringe driver she did not have any water or fluids and took a long time to deteriorate. This was because she was previously very well nourished and had bodily reserves that would sustain her for a while.

54. Whilst mum was on the syringe driver she was not having any fluids. They put a catheter in and the bag was just hanging over the side of the bed containing congealed urine. I asked a nurse to change the bag and she said she wouldn't do until it was full. I said that my mother had had no fluid so was not going to be passing any more urine.

55. My mum was clearly dehydrated. I used a sponge and would wipe her lips. She was unconscious but she would have a reaction and try to suck in when the water was next to her lips.

56. My mum died on 21 August 1998.

57. Exhibited to this statement and marked "**LOB/6**" is a copy of notes that I made whilst my mother was still alive. As I was not happy with the care in the GWMH at the time I started to keep notes contemporaneously. I had telephoned Portsmouth Healthcare NHS Trust prior to my mother's death and they confirmed that all complaints needed to be in writing. The original copy showed entries in different inks on different days.

58. I put a number of questions into the document. On 22 September 1998 I received a response from Max Millett, the Chief Executive of Portsmouth Healthcare NHS Trust. This attempted to answer my concerns. I exhibit the letter of 22 September 1998 marked "**LOB/7**". I was not satisfied with the response and made further comments to the hospital. Exhibited to this letter and marked:-

    (a) LOB/8 – This is my answers to their response which were not the truth and were evasive comments.

    (b) LOB/9 – This was produced when I was asked to comment on the answers which were given after investigations on the response.

    are two different responses that I made to the Portsmouth NHS Trust letter.

59. My sister, Gillian, and I both went to Gosport Police Station quite soon after our mother's death as we were not at all satisfied with the answers to our questions from the trust and felt the matter required further investigation.

60. I understand that my statement may be used in evidence for the purposes of a hearing before the General Medical Council's Fitness to Practise Panel and for the purposes of any appeal, including any appeal by the Council for Healthcare Regulatory Excellence. I confirm that I am willing to attend the hearing to give evidence if asked to do so.

I believe that the facts stated in this witness statement are true.

Signed: Code A

Lesley Frances O'Brien

Dated: 03 04 08. **Code A**

General Medical Council

Dr. Jane Barton

Exhibit LOB/1

This is the Exhibit marked "LOB/1" referred to in the statement of Lesley O'Brien:-

- Statement made to Hampshire Police dated 31 January 2000

Code A

Code A

Code A

Code A

Code A

Code A

Code A

Code A

General Medical Council

Dr. Jane Barton

Exhibit LOB/2

This is the Exhibit marked "LOB/2" referred to in the statement of Lesley O'Brien:-

- Further statement made to Hampshire Police dated 11 August 2004

Code A

Code A

Code A

Code A

General Medical Council

Dr. Jane Barton

Exhibit LOB/3

This is the Exhibit marked "LOB/3" referred to in the statement of Lesley O'Brien:-

- Photographs taken of my mother (Gladys Richards) at her 90th birthday party

Code A

Code A

Code A

General Medical Council

Dr. Jane Barton

Exhibit LOB/4

This is the Exhibit marked "LOB/4" referred to in the statement of Lesley O'Brien:-

- Copy of notes regarding my mother's treatment in Glen Heathers Nursing Home dated August 1998

Re Gladys Mabel Richards.

Following my Mothers admission to Haslar with a fractured neck of Femur - I was asked by the Social Services Dept why I had stated that if and when my Mother recovered she would not be returning to the Nursing Home she came from. The level of care is no longer acceptable to me. The following is a catalogue of unacceptable events over the past seven months culminating in the latest accident from which I made the decision.

December 97. Just after Christmas. Heavy fall. with severe facial bruising. No phone call. Found on normal daily visit. Staff surprised I had not been told. Mother continually moaning and holding her head. Pain in shoulder. Medication changed following Consultants visit. Appoint with GP. to discuss this. Mothers speech affected. Hearing aids (both ears) lost yet again. Frequent requests over 7 months for renewal - no result.

March. Fall hurting ribs. Mother clutching side. No Xray as quote "They dont do anything for ribs nowadays". Request from N. Home to increase her medication, as mother calling & "wailing".

April. On visiting at lunch time found sitting in lounge with wet hair. On enquiry found hair had been washed in bath. ? Why when she had the hairdresser each week. Two days later developed cough generally unwell. Brought to the attention of staff. daily. 5 days later very poorly. Copious mucous & coughing holding her side Requests for GP to see from family Mother very poorly. 5 days before seen by GP.

April 11th. Fall Pain in hip — to Haslar for Xrays. No bony injur.

Very shocked. Night time Discharged back to home Family visiting for lunch & supper daily and sometimes for breakfast. Good days & bad days Glasses lost staff requested to look for them please. No result. Mother deaf in both ears is now existing with no form of communication other than staff shouting at her and now without her glasses (post cataract op) so she cannot see properly. She is almost blind in the other eye from another cataract.

April 22nd. Collapse in dining room. Telephoned from Home to come. Mother unconscious. Home don't know what happened. "Collapsed" at dining table and put to bed.

Family nursed Mother day and night for the next approx 10 days as staff stated they could not watch her. Mother regained consciousness but was very poorly. She remained continent. Attempting to get out of bed or chair if she needed the toilet. Staff again stated they could not watch her. She was very ill and remained in her room. I stayed during the day - my sister slept in the room during the night. When Mother wanted the loo during the night - although the bell was rung - my sister stated staff do not respond and my sister toileted my Mother. There were no falls during the period we stayed.

May. Told by staff that my Mother had been 'lost' for over an hour at night and finally found down the back stairs. Told by staff Mother wanders - always around 2am. - All she needs is taking to the toilet and settling back to bed.

Decision made to have Ground floor room.

Wesley visiting daily Throughout lives remain for lunch & supper most days – but always for supper.

16th July. Fall at 7.45 am. Getting up to go to loo on her own. Cut to bridge of nose and forehead grazing large facial swelling. To Hasbal. I went with her. X-rays and head scan done. Back to N. Home 1.30pm.
Visited and fed daily.

17th July Electronic pad put by bedside to alert staff if Mother got out. Frequently found to be unplugged.
Told by other relatives that Mother was left in lounge till 10.45pm.
I stayed to stay later after I had fed her her supper.

21st July. Phoned 10am to say I could not visit today 3pm My sister visited about 10.45 – 11am. Asked where Mother was. Told she has put herself back to bed. Found to be at the bed Head against the wall sideways on. Foetal position across the bed. Still no visit from GP following fall.

23rd July. Asked for help following supper to put Mother to bed. She had been very poorly daily since 16th and I no longer could manage her without help. Shirley RGN said she would send a carer to help me when she could. At 8.15pm Diane came to help me. Mother put on the toilet and washed and undressed and nightie put on. Taken to bed – sat on bed and legs lifted to bed to take tights off. Nurse C/asst. and I removed her tights which were clean to discover dried hard faeces covering sole of foot and up between each toe to the front surface of her foot: A warm soapy flannel removed the faeces and the RGN in charge was informed in front of staff in the office for handover.

11. Spoke to care assistant Jackie who had got my Mother up the previous day. She stated she must have stepped in it during the day. This is not feasable as there was no dirt on slippers or tights. I suggest She was not checked in the morning

July. Mother taken to the toilet by me. Found to be red on her buttocks with very small 'skin off area' I Opened door from toilet and asked care asst for a clean pad and 'whatever cream' is used here for sore buttocks. I was given a large container of E.45. I explained I did not want a moisturiser for a moist area. She said Im only a care asst, I dont know! I saw Sue RGN through the door. Request repeated. Mother still standing by the toilet distressed at waiting Sue brought E.45. Explained again. Sue said Youll have to wait if you want something else Im busy. I waited. I washed mother and put clean pad on and walked her back to the lounge. Sue came 20 mins later. saying "stores" are not due till tomorrow but I have put some drapolene into a small pot for Mothers use. I asked the care asst I saw to please apply some to the sore area when they next took her to the Toilet.

Next day I told Margaret RGN that the small area broken.

3 days later I asked Margaret How was Mum's bottom She replied I dont know I havnt seen it yet.

July. My daily visits continued.

My mother still without hearing aids or glasses and I am told that the Hearing Aid Dept have no priority for those over 90. Mum is 91 - but she was 90 when they were lost.

Wed 29th July.

Could not get to the N. Home for lunch time feeding as I was at the Radcliffe in The Avenue feeding another Grandma as my daughter was away. Rang home to tell them I'd be in later.

I arrived at 3.50pm. Mother was laying in her arm chair – anxious expression I asked a care assistant to help me sit Mother up. We did so with difficulty and my Mother screamed out. I saw John Perkins RGN Matron/Manager in the hall doorway. I asked if there was anything wrong with Mother – Is she OK. She's fine he said. I explained I would not be here to feed her at 5pm as I had to get to Southampton Airport To had delayed flights from Guernsey so my timing was out. I left at 4.15. I arrived back home at 6.10pm. Message on my answerphone at 3.28pm. from Margaret RGN. Your Mother had a little fall earlier. She is alright but a bit noisy and upset. I know you come at teatime but could you come earlier and sit with her.

4.15pm I rang the Home. I spoke to John Perkins RGN. I asked about the message. I said I've seen you since the message and spoken to you.

Yes he said. but I did not know about your Mum's fall till it was mentioned at the 6pm handover when Margaret went off duty. Well how is she I asked. – well she is OK now he said.

Right I said my daughter has a meeting in Fareham 7pm 8pm. I'll call when I get back from her house. I got back at 8.30pm. 3 messages on my answerphone.

① 8.08pm John. Your mother is quite agitated & noisy perhaps you would like to come & sit with her.

2) 8.29. Mother is calling as if she may have pain We have given her to bed I may call the Doctor.

3) It's Sue here – night staff. I'm sorry but I'm sure you're Mother has a fractured Femur. When I came on John said Go and see Gladys – she has been shouting for ages and when I saw her it was obvious. I've called an ambulance.

I rang back and said I'd meet the ambulance at Haslar.
On admission the Xrays were consistant with having been walked since fall. There was shortening of limb with external rotation of foot
Despite the injuries and the trauma – things are even worse because of her inability to hear.
The frustrations of Xray – Drips – keeping still etc have been exhausting for all concerned and not least Mum who could not hear and cried and wailed in fear.

As a family we have wanted to move Mum for some considerable time and have discussed this but felt the move would be unfair as she knew her surroundings and where things and rooms where She was familiar on a day to day basis.

I asked for a full explanation from Glen Heathers for the 29th.
We had a interview with Pauline RGN. Consultant Advisor to Glen Heathers
Several statements from staff were read out to us.

They confirmed

The fall was at 2.50pm.
It was in the dining room.
What was she doing in the dining room at
this time following 12noon lunch? No answer.
Frequently those sitting quietly at the table are
left in this room. If Mum was left - she would
have attempted to get up to go to the loo.
The statements show she was walked to the lounge
" " " " " - to the
bedroom from the lounge.
I do not know what time this was.
A Dr was not called.

Fall at 2.50pm.

To Hasler at 9pm.

Walked twice in the meantime.

(There are numerous incidents I could relate.
RGN raised voices. Care shocking at residents
Call system going for ages.
Moths named clothes on other residents
Drawers full of other peoples clothes
In 10 days following Mothers collapse in April John
did not visit the room once.
Constant requests for hearing aids made me feel a nuisance
I could go on).

The above events are a true statement

August 1998.

Code A

General Medical Council

Dr. Jane Barton

Exhibit LOB/5

This is the Exhibit marked "LOB/5" referred to in the statement of Lesley O'Brien:-

- Copy of fluid balance charts

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

134

Code A

Code A

General Medical Council

Dr. Jane Barton

Exhibit LOB/6

This is the Exhibit marked "LOB/6" referred to in the statement of Lesley O'Brien:-

- Copy of notes I made after my mother died

General Medical Council

Dr. Jane Barton

Exhibit LOB/7

This is the Exhibit marked "LOB/7" referred to in the statement of Lesley O'Brien:-

- Letter dated 22 September 1998 from Max Millett, Chief Executive of Portsmouth Healthcare NHS Trust

PORTSMOUTH
HealthCare
NHS
TRUST

Mrs. L. Lack,

Code A

Our ref
MM/BM/YJM
Your ref

Date
22nd September, 1998
Ext
Code A

Dear Mrs. Lack,

I am writing further to my letter of 25th August, 1998 now that I have received the report from Mrs. Hutchings, who has been investigating all the matters you raised concerning the care provided for your mother, Mrs. G. Richards, prior to her death on Friday, 21st August, 1998.

I should like to reiterate how very sorry I am that your grief has been compounded by so many concerns, but that you for having taken the trouble to write, as this has resulted in a very thorough investigation, and given us the chance to explain and/or apologise for the problems you identified. It has also meant that staff have reviewed procedures and improvements are being implemented as a result.

I should like to respond to each of the points you made, using the numbering system from your notes.

1. At what time did Mrs. Richards fall?
   She fell at 1330 on Thursday, 13th August, 1998 although there was no witness to the fall.

2. Who attended her?
   She was attended by Staff Nurse Jenny Brewer and Health Care Support Worker Cook.

3. Who moved her and how?
   Both members of staff did, using a hoist.

PORTSMOUTH HEALTHCARE NHS TRUST CENTRAL OFFICE

St James' Hospital
Locksway Road, Portsmouth, Hants PO4 8LD
Tel: 01705 822444 Fax: 01705 293437

4. After the fall
Your mother had been given medicationi presecribed 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.

5. Why was there such a delay in dealing with the consequences of the fall?
With the benefit of hindsight it is possible to assume that your mother's dislocation could have been identified much earlier and we can now only apologise for that delay if that was the case. It is notoriously difficult to establish degrees of pain or discomfort in dementia sufferers, but staff now recognise that more attention should have been paid to your mother's signs of discomfort, and your own expressed concerns about that.

6. Why no x-ray? Why no transfer?
These delays were a direct result of the failure to identify a problem earlier in the day - because the x-ray department at Gosport War Memorial Hospital only operates from 9 a.m. to 5 p.m. I understand that you did appreciate this when it was discussed with you on the Thursday evening, and agreed with the advice that it would be best to defer a transfer to Haslar until an x-ray based diagnosis had been made. The transfer to Haslar was organised as soon as possible after the situation had been confirmed by x-ray, on the morning of Friday, 14th August, 1998. It is a matter of great regret that this delay occurred, and we accept and apologise for the fact that the standard of care fell below that which we aim to provide.

7. Why when she was returned to bed from the ambulance was her position not checked?
When your mother arrived on the ward two health care support workers saw her into bed and then went to inform Staff Nurse Couchman that your mother had arrived. They had realised there was a problem and that professional advice was needed. Staff Nurse Couchman came and checked her position, and I believe you assisted her in straightening your mother's leg and placing a pillow between her legs.

8. (a) How was she brought from Haslar?
She was brought by an ambulance with two crew.

(b) Was there an escort/anyone in the back with her?
There was no nurse escort - this would have been arranged by Haslar had it been thought necessary.

(c) When did she start to show pain and what caused it?
The ambulance crew commented that she showed signs of being in pain as she was put into the ambulance. The cause of the pain has not been specifically identified.

/continued - page 3

(d) Why was my request to see the x-rays denied?
The x-rays were seen in the x-ray department by the doctor and the consultant radiologist. The decision to keep x-rays in the department and not to send them to the ward rests with the consultant radiologist, not the ward staff, and your request may not have been relayed to the department.

(e) Decision to do nothing but provide pain relief?
Dr,. Barton felt that the family had been involved at this stage as she discussed the situation fully with you. She made sure you were aware that the surgical intervention necessary for the haematoma would have required a general anaesthetic and clearly your mother was not well enough for such a procedure to be undertaken. Therefore, the priority, and only realistic option, was to keep her pain-free and allow her to die peacefully, with dignity.

9. Clothing sent for marking despite being named already
As a result of previous problems the ward have adopted the practice of marking all patients clothing with the ward name - a procedure designed to help, which on this occasion, did the absolute opposite. The laundry marker at Gosport War Memorial Hospital had broken down, so your mother's clothes were sent to St. Mary's Hospital and meanwhile she was given hospital clothing. In attempting to meet your completely reasonable request for her own clothes to be returned, a taxi was authorised which in the event brought the clothes back - still only bearing your mother's name. Whilst, as you say, this was a trivial problem on the scale of the real issues, it was a quite ridiculous consequence of a well-intentioned policy which served to cause unlooked for stress. The process is being reviewed as a result of your complaint.

All the staff concerned with the care of your mother were deeply saddened at her experience, and sincere apologise are proffered to you and your sister for the problems which occurred, and the failure of the service to meet your very reasonable expectations. The only constructive aspect I can identify is that lessons have been learned and the experience will benefit future patients, although I fully appreciate that such benefits have little relevance to yourselves.

You may be aware that your sister, Mrs. McKenzie, has telephoned Mrs. Hutchings as she wishes to see this correspondence. I am writing to her to confirm that it is personal to you, although, of course, I hope that you will feel able to share it with her. If you unable to do this then she will need to raise a complaint of her own.

/continued - page 4

Should you wish to pursue the matter further my secretary would be very happy to arrange a meeting with Mrs. Barbara Robinson, Hospital Manager, at your convenience and I would be grateful if you could contact her on Code A within one month should you wish this.

Thank you once again for writing so comprehensively of your concerns.

Yours sincerely,

Code A

Max Minett
Chief Executive

General Medical Council

Dr. Jane Barton

Exhibit LOB/8

This is the Exhibit marked "LOB/8" referred to in the statement of Lesley O'Brien:-

- Response to GWMH response to complaint re Mrs Richards' care

Mrs. L. LACK,

Code A

MM/BM/YJM

22nd September, 1998.

Code A

Dear Mrs. LACK,

I am writing further to my letter of 25th August, 1998, now that I have received the report from Mrs. HUTCHINGS, who has been investigating all the matters you raised concerning the care provided for your mother, Mrs. G RICHARDS, prior to her death on Friday, 21st August, 1998.

I should like to reiterate how very sorry I am that your grief has been compounded by so many concerns, but that you for having taken the trouble to write, as this has resulted in a very thorough investigation, and given us the chance to explain and/or apologise for the problems you identified. It has also meant that staff have reviewed procedures and improvements are being implemented as a result.

I should like to respond to each of the points you made, using the numbering system from your notes.

1. At what time did Mrs. RICHARDS fall?
She fell at 1330 on Thursday, 13th August, 1998, although there was no witness to the fall.

2. Who attended her?
She was attended by Staff Nurse Jenny BREWER and Health Care Support Worker COOK.

3. Who moved her and how?
Both members of staff did, using a hoist.

4. After the fall
Your mother had been given medicationi presecribed 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.
Why didnt Dr Barton examine my Mother who was in pain. The dislocation would have been obvious to the eye. I did not object to the medication in principle - but its misuse on 11. & 12 8 98 when my Mother was not in pain. and therefore it knocked her out so she could not take anything to eat or drink

5. Why was there such a delay in dealing with the consequences of the fall?
With the benefit of hindsight it is possible to assume that your mother's dislocation could have been identified much earlier and we can now only apologise for that delay if that was the case. It is notoriously difficult to establish degrees of pain or discomfort in dementia sufferers, but the staff now recognise that more attention should have been paid to your mother's signs of discomfort, and your own expressed concerns about that.

It is not an assumption that the dislocation could have been identified It is a fact. The dislocation had occured and examination would have found it, with confirmation by Xray. No attention was paid to my fears or anyone trying to discover the cause of pain. It would not have been a difficult thing to determine.

6. Why no x-ray? Why no transfer?
These delays were a direct result of the failure to identify a problem earlier in the day - because the x-ray department at Gosport War Memorial Hospital only operates from 9 a.m. to 5 p.m. I understand that you did appreciate this when it was discussed with you on the Thursday evening, and agreed with the advice that it would be best to defer a transfer to Haslar until an x-ray based diagnosis had been made. The transfer to Haslar was organised as soon as possible after the situation had been confirmed by x-ray, on the morning of Friday, 14th August, 1998. It is a matter of great regret that this delay occurred, and we accept and apologise for the fact that the standard of care fell below that which we aim to provide.

7. Why when she was returned to bed from the ambulance was her position not checked?
When your mother arrived on the ward two health care support workers saw her into bed and then went to inform Staff Nurse COUCHMAN that your mother had arrived. They had realised there was a problem and that professional advice was needed. Staff Nurse COUCHMAN came and checked her position, and I believe you assisted her in straightening your mother's leg and placing a pillow between her legs.

8. (a) How was she brought from Haslar?
She was brought by an ambulance with two crew.

HAMPSHIRE CONSTABULARY

C.51 4/96

Identification Ref. No. LFL/3A

Court Exhibit No.

R - v -

Description LETTER (LFL/3) WITH COMMENTS

Time / Date Seized / Produced

Where Seized / Produced

Seized / Produced by

Signed **Code A**

Incident/Crime No.

Major Incident Item No. E17

Laboratory Ref:

(b) Was there an escort/anyone in the back with her?
There was no nurse escort - this would have been arranged by Haslar had it been thought necessary.
As she screamed as soon as she was put in the ambulance why was she left alone in the back. She must have been very frightened and unable to communicate properly.

(c) When did she start to show pain and what caused it?
The ambulance crew commented that she showed signs of being in pain as she was put into the ambulance. The cause of the pain has not been specifically identified.
Why not? She left hospital pain free. She screamed in the ambulance and noone did anything.

(d) Why was my request to see the x-rays denied?
The x-rays were seen in the x-ray department by the doctor and the consultant radiologist. The decision to keep x-rays in the department and not to send them to the ward rests with the consultant radiologist, not the ward staff, and your request may not have been relayed to the department.

(e) Decision to do nothing but provide pain relief?
Dr. BARTON felt that the family had been involved at this stage as she discussed the situation fully with you. She made sure you were aware that the surgical intervention necessary for the haematoma would have required a general anaesthetic and clearly your mother was not well enough for such a procedure to be undertaken. Therefore, the priority, and only realistic option, was to keep her pain-free and allow her to die peacefully, with dignity
This was not the only realistic option when Haslar had offered to see Mrs Nelson again

Being denied any form of nourishment and therefor inducing kidney failure does not come under to die peacefully with dignity. There is no dignity in the refusal to remove a caether bag which had about 200mls of stagnant fluid on the 19.8.99 and remained in place until the time of death with no fluid passed urine. If peacefully means she was unconcious throughout and so did not speak a call out then that was indeed achieve It was an induced death due to lack of basic needs of the living.

9. Clothing sent for marking despite being named already

As a result of previous problems the ward have adopted the practice of marking all patients clothing with the ward name - a procedure designed to help, which on this occasion, did the absolute opposite. The laundry marker at Gosport War Memorial Hospital had broken down, so your mother's clothes were sent to St. Mary's Hospital and meanwhile she was given hospital clothing. In attempting to meet your completely reasonable request for her own clothes to be returned, a taxi was authorised which in the event brought the clothes back - still only bearing your mother's name. Whilst, as you say, this was a trivial problem on the scale of the real issues, it was a quite ridiculous consequence of a well-intentioned policy which served to cause unlooked for stress. The process is being reviewed as a result of your complaint.

My Mother had no clothing items of her own from 12.8.98 until the day before her death when I was anguished at seeing her dying in borrowed nightwear — when she had plenty of nice things of her own.

All the staff concerned with the care of your mother were deeply saddened at her experience, and sincere apologise are proffered to you and your sister for the problems which occurred, and the failure of the service to meet your very reasonable expectations. The only constructive aspect I can identify is that lessons have been learned and the experience will benefit future patients, although I fully appreciate that such benefits have little relevance to yourselves.

Please specify what lessons have been learned.

You may be aware that your sister, Mrs. McKENZIE, has telephoned Mrs. HUTCHINGS as she wishes to see this correspondence. I am writing to her to confirm that it is personal to you, although, of course, I hope that you will feel able to share it with her. If you unable to do this then she will need to raise a complaint of her own.

I had informed you that Mrs Mackenzie should have copies of all correspondence regarding my Mother.

Should you wish to pursue the matter further my secretary would be very happy to arrange a meeting with Mrs. Barbara ROBINSON, Hospital Manager, at your convenience and I would be grateful if you could contact her on 01705 894378 within one month should you wish this.

Thank you once again for writing so comprehensively of your concerns.

Yours sincerely,

Max Millett
Chief Executive

Silent copy to Mrs. B. ROBINSON
Mr. W. HOOPER

General Medical Council

Dr. Jane Barton

Exhibit LOB/9

This is the Exhibit marked "LOB/9" referred to in the statement of Lesley O'Brien:-

- Response to GWMH response to complaint re Mrs Richards' care

A.

COMPLAINT MADE BY MRS. L. LOCK RE. STANDARDS OF CARE FOR HER LATE MOTHER MRS. GLADYS RICHARDS WHILST A PATIENT ON DAEDALUS WARD - G.W.M.H FROM 11.08.98. TO 14.08.98. AND 17.08.98. TO 21.08.98.

1. At what time did Mrs. RICHARDS fall?

Answer - 1330 hours on 13.08.98.

NOK not informed as stated on accident form.

2. Who attended to her?

Answer - S/N Jenny BREWER and H.C.S.W. COOK

3. Who moved her and how?

Answer - S/N Jenny BREWER and H.C.S.W. COOK using a hoist.

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

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

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

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

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

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

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

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

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

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

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

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

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

Why no transfer?
As above.

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

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

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

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

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

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

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

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

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

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

(c) Request to see x-rays denied?

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

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

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

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

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

TRIVIAL CONCERNS RE CLOTHING/LAUNDRY

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

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

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

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

My Mothers clothing was returned a day or two before she died. In the meantime I had to see her lay in Hospital clothing that was ill fitting and not as my Mother was used to. Everything was gone including bedjacks and towels. Totally unnessary.

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

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

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

ANALYSIS OF EVENTS

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

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

Ref * AF/1C/11 Haslar H[illegible] Notes.

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

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

Wednesday 12th August, 1998

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

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

Thursday, a.m. 13th August, 1998

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

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

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

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

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

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

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

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

HAND WRITTEN NOTE ATTACHED TO PAGE 9

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

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

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

Friday 8.00 a.m. 14th August, 1998

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

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

Monday 11.45 a.m. 17th August, 1998

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

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

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

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

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

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

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

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

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

POST-IT NOTE
ATTACHED TO
PAGE 12

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

she felt her mother was on her bed too much and this would not help with rehabilitation.
During her last day of life Nursing Staff were prevented from removing Mrs. RICHARDS' dentures as part of mouth care as the daughters said they were not to remove them.

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

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

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

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

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

CONCLUSION

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

RECOMMENDED ACTION PLAN (to be agreed with Service Manager)

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

2. Review nursing records and documentation.

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

4. Review marking of clothing "policy".

General Medical Council

Dr Jane Barton

Statement of Diane Mussell

I, **Diane Mussell**, will say as follows:

1. I am the daughter of Ruby Lake.

2. Exhibited to this statement and marked **DM/1** is a copy of my witness statement dated 12 April 2005.

3. I can confirm that I have been given the opportunity to add to or amend this statement and wish to make the following changes:

4. I would like to remove the first sentence of my statement as my address is not shown overleaf.

5. The words '...when she died' in the final sentence of the second paragraph should be deleted.

6. The word 'down' should be removed from the second sentence of the fifth paragraph.

7. The fifth word on the second page should read 'she' not 'he' as stated.

8. In the second paragraph of the second page it should state 'However, these were things that affected her in the later stages of her life.'

9. The fourth paragraph of the second page should read 'visited' not 'would visit' as stated.

10. The final paragraph of the second page should read 'I was assured she was fit enough to be moved...'

11. The words 'went and' should be deleted from the first paragraph of the third page.

12. The fourth sentence of the third page should read '...a hip operation to cause her demise.'

13. I understand that my statement may be used in evidence for the purposes of a hearing before the General Medical Council's Fitness to Practise Panel and for the purposes of

any appeal, including any appeal by the Council for Healthcare Regulatory Excellence. I confirm that I am willing to attend the hearing to give evidence if asked to do so.

I believe that the facts stated in this witness statement are true

Signed: Code A

Dated: 3-6-08

Code A

Code A

Code A

Code A

General Medical Council

Code A

Statement of Code A

I, Code A, will say as follows:

1. I am Code A

2. Exhibited to this statement and marked **PR/1** is a copy of my witness statement dated 21 July 2005.

3. I can confirm that I have been given the opportunity to add to or amend this statement and wish to make the following change.

4. The final paragraph of the statement should be replaced with:

   'Although we were all surprised ay the speed of Code A s decline and subsequent death following her transfer from Haslar Hospital to Gosport War Memorial Hospital, I appreciate that an elderly patient having undergone traumatic surgery, such as a hip replacement in her case, may incur complications resulting in an early death.'

5. I understand that my statement may be used in evidence for the purposes of a hearing before the General Medical Council's Fitness to Practise Panel and for the purposes of any appeal, including any appeal by the Council for Healthcare Regulatory Excellence. I confirm that I am willing to attend the hearing to give evidence if asked to do so.

I believe that the facts stated in this witness statement are true

Signed: ..... Code A

Code A

Dated: .....2 June 2008

General Medical Council

Code A

Exhibit PER1

This is the Exhibit marked "PER1" referred to in the statement of Code A :-

- Statement dated 21 July 2005 (regarding Code A)

Code A

Code A

Code A