

Other Document Form

Number

D1299

Title Letter Acknowledges for Gillis Package 19.1.2005..
(Include source and any document number if relevant)

Receivers instructions urgent action Yes / No S.I.O. Method :- Please

Type letter 11 pages of Benhabris in full..
Research forwarded to Gordon's Books club

Document registered / indexed as indicated appropriate..

No(s) of actions raised Code A S.I.O.
21.1.05

Statement readers instructions

Indexed as indicated

No(s) of actions raised

Examined - further action to be taken

Further actions no(s)

Code A

O/M	SIO
Indexer	

When satisfied all action raised Office Manager to endorse other Document Master Number Form.

Code A

19. 1. 2005

Dear Supr. 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 & 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. Had'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

I have previously raised with her.
 other points I wish to raise ^{again} / except for her'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 C.I.D on two occasions.

As I have pointed out to you before in
 writing 6 August 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 Code A Code A ~~Owen Kenny~~ 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 Coconur! She continued later she had to look up the difference between Designated and Dedicated.

I find it extremely stressful to cope with this level of education as she does with me. There has been enough stress caused by the Police over a period of 6 years. I now have in writing the alleged comments of the Readhead concerning Ray Burt, which has caused me a great deal of personal distress.

Yours sincerely

Code A

P.S. I would be grateful for an acknowledgment of this letter and whether the points raised are of any value. Of course this does not apply to comments re. Hestley.

P.S. I confirm I should not of relied on Hestley to comment fully - she did not want me to go to the Police in the first place

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

Para. 1.

How is it that my mother's named consultant Dr. Had was unaware of Lesley Humphries Report for Mr. Nullett. Pitman's Healthcare Trust until her request on the 17 December.

This paragraph is a Defense. 'Discussions with Philip Beed' and Barbara. Does 'has not had access to Haslar records' Surely she should have been aware of the Report and complaint before the 17 December 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 fall on 13/8/98 or Drugs written up on arrival 11/8/98 or Barbara's comments 'Quite happy for Nursing staff to confirm death'. Obviously in defence of Barbara. I have commented on P 30 of 7th, rather unresponsive following sedation. Had should have understood why. I was the daughter present at 1pm. Beed did not give her morphine. It was an injection. See my Statement. & 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 morphine. My mother had another injection before going to X ray. 45mg. Morphine in 24 hour period. Did they advise my mother to consciousness every 4 hours to give her morphine - Robbish. See my notes P 30 of 7th. Decision taken for Sympie Duvee at 18.8.98 discussion with Beed only. - Barbara was not present. We were informed by Beed nothing more could be done & 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 & so agreed the Sympie Duvee. 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 lithotripsy (Kidney Stone) given pain relief 'pethidine' I was moaning but conscious & 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.

Given to Lesley Lack for comments. none given
except paragraph 9. - not adequate.

9

Re- late Gladys Richards - DOB 13/04/07

1 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.

2 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

3 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.

4 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

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 substantial 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 of pain and distress - mother was still 'out' from the time she left X ray on the 17. 8. 98.

Para 5

Halo peridol had been written up on the 11. 8. 98. but not given by Reed who preferred to keep mother sedated by oramorph. My mother had Halo peridol at the Nursing Home for a good night's sleep but not this dose. 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 earth was Wesley doing to allow her mother to be dosed with Neuroleptics plus other drugs. I was only aware of drugs at her on Solent and I thought she had been on them from Dec/Jan 98. Wesley & the GP never mentioned the various cocktails she had been on/off before. There are notes regarding my objections on medical notes here on Solent GP & Nursing Home records. Inability to communicate, - no hearing aids or glasses - I can find no medical records of catheter removal at Moorfields from Basingstoke onwards or at her on Solent. Side effects of neuroleptics can cause loss of coherent speech. Dr. Banks comments my mother was allergic to Mefenid 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 'as per medical notes do not confirm - the reverse.' Mrs Richards could not understand - she was unconscious! Hyposine would dehydrate all fluids - excretions including the heart & lungs - also skin. It dries you out. Often in cough mixtures but not at this dose level. My mother was not transferred to Haslem for a surgical procedure - the desubstitution 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 BHA letters to the Times from Medical Experts will confirm. Jan 6-9 1999 Sent to Dr. Morgan

Para 8.

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

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

5 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.

6 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.**

7 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 significantly 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 Halsar 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.

8 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**

9 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.

*THIS INFO IS NOT COLLECTED
DRUG GIVEN EARLY
SEE NOT (Hospital)
11/12/8*

Code A
Dr. A. LORU, Consultant Geriatrician
22/12/98

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

Para 9.

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

Les Hesley & I agreed to Sumpce Drive with Beed. see previous comments.

Lord places ~~that~~ these discussions fully with Beed. There is no reference to Barkan and general anaesthesia for a haematoma as contained in Humphrey's Report or as confirmed by Beed to Code A as per my statement

27.4.99 Lord would have known you do not treat a haematoma with surgery or a general anaesthetic - and of course there is no write up in the medical notes or evidence of a haematoma. Lord makes no comments in defence of Barkan & Beed.

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

Code A

14/8/98

Haslar A&E

Patient to A&E for reduction of dislocated R Hip.

No change in treatment since transfer to us 14/8/98,
except ~~discontinuation~~ addition of Oramorph PRN.

10mg Oramorph given at 1150.

We will be happy to take her back following
reduction of the dislocation.

Code A

P. BEED c. Nurse.

PTO

Page 22 of 714.

This is not correct. (See Drug Chart).
 Oramorph given by Philip Beed. 11 August shortly after
 admission. x2 plus 12 13 14 August. Lesley Mack
 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 haste
 to commence oramorph despite the fact that the letter
 from Haslam to the August (typed up on the evening before
 discharge from Haslam) states pain killer PRN Cocodamol. Has a
 Detective checked the Haslam file which was missing from the papers
 sent to Fonesc? (Do I have to act as 'law Expert' - Detective.
 See also Barvati's comments 14.8.98 Very sensitive to Oramorph
 Mother was 'out for the count' Page 29 of 714.
 Oramorph written up by Barvati 11.8.98. Beed quiet off the unit.
 Ctl Reprt. "No pain assessment procedures in place."
 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 meaning of a dementia patient and a scream.
 Lesley will confirm as the Nursing Home notes confirm
 what was.

Code A

MF 200

UNIT NO

S.M.W. MF

Qura HOSPITAL

Nam 6099198
(Sui RICHARDS GLADYS QD2
Adc GLEN HEATHERS
NURSING HOME
MILVIL ROAD
LEE ON SOLENT

DOB 13.04.1907 PO13 9LU
DR JH BASSETT 13040707
Family Dr.

HISTORY SHEET

DATE	CLINICAL NOTES (Each entry must be signed)
11-9-78	<p>Transferred to Paddock Wood Community Hill (H) no further 30-9-78</p> <p>Post hysterectomy 1955 subsequent operations hernia Arteriosclerosis</p> <p>1/2 depression front hematomata not obviously in pain pleasant wife comfortable</p> <p>transfer with horse wondering confusion needs help with 4th breast 2.</p> <p>I am happy for many days to begin double</p>
14-9-78	<p>Sedation / pain relief has been a problem seemingly not controlled by haloperidol 1mg but very sensitive to promethazine.</p> <p>Full one of chain last night (Q) hair shortness and internally rotated paralytic wave and not happy pleas X-ray Is this way well enough for another surgical procedure?</p>

Code A

Code A

P.T.O.

Drugs written up without proper assessment - see Red's letter - Hadan staff statements - Hadan file - my mother was transferred to Gosport "for 2-4 weeks" to give Lesley time to find a Suitable Nursing Home on discharge. See Hadan file notes.

Barbar notes. 11.8.98. "Not obviously in pain"

why did Beed administer diamorphine?
14.8.98. 'Fell out of chair last night' who told her (Barbar) that? She fell at 13.30 previous day. See Gosport file.

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

Barbar 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 here every day) at the Royal Marsden. I was aware of the palliative care drugs for my husband + these were discussed fully with my husband and myself. I have also had experience as a volunteer "gator" in the local hospice.

G. H. Macfieuzie.

DATE	CLINICAL NOTES (Each entry must be signed)
14-8-78	<p>Learn 7. Mr Spalding Further to our telephone conversation thank you for being this important lady who helped framed him at 1.20 pm yesterday with letters to have returned to his Home where party was held on 30-7-78 I am sending things across He has had 2 1/2 ml of log/500 amount at midday tonight</p>
17-8-78	<p>Readmission to Laidlaw from KKH closed retention under iv sedation remained unconscious for 2 and hours now appears peaceful Low carbic haloperidol only give over night in 2000 and see tonight again</p>
19-8-78	<p>Still in great pain main problem 1 mg gas 50 Adrenorphie / Haloperidol / midazolam 1 ml 200 haloperidol today Home with tonight</p>
21-8-78	<p>Much more peaceful now to hyaline for 2000</p>
21-8-98	<p>condition very poor pronounced dead at 21-20 hrs by S/N Sylvia Roberts Dyff Siffell relatives present (2 daughters) in for cremation</p>

Code A

Code A

Code A

Code A

Code A

PTO.

Page 30 of 714.

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. 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. There are discrepancies here.
Why hasn't Karen Reed been interviewed and not come
forward? Karen Reed one of Lesley's daughters and an
ex Harlow Orthopaedic Nurse.

17.8.98.

Remained unresponsive for some hours. - Not surprising
with Oramorph 11, 12, 13, 14 followed by IV Sedation,
at Harlow.

"They give Oramorph in severe pain." Reed quiet off the
nurse. 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. Reed had been informed there was no
canvas. A canvas was on the back of the chair
in my mother's room. Why didn't Reed ensure that it
was used to transfer my mother from the ambulance to
the bed. See CHI Report and my statement (Balderstone).

18.8.98.

"Still in great pain" Rubbish - she never regained consciousness
from recovering from X-ray approximately 4.30 17.8.98.
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. Reed gave her an injection
at 1pm and another just before she went down to X-ray
approx. 3.45. You do not reject Oramorph. See my
Statement. I strongly question the Drug chart for 17.8.98

Mother received nothing after recovering from X-ray and Lesley and
I did not leave until well after 8.30pm. If mother was
given Oramorph on the 18th. 2.30am and 4.30am did
they wake her up to give it to her by mouth? Mother was 'out'
when we arrived on the 18.8.98 shortly after 9am on the 18.8.98
when we were interviewed by Reed alone.

Code A

4

MR411	Sheet No.	Hospital	Ward
CONSULTANT DR. A. LORD ²		GLOMME	DAEDAWLS
ALLERGIES AND DRUG SENSITIVITIES	Unit No.	G099198	Q02
		RICHARDS GLADYS	
	SURNAME	GLEN HEATHERS	
	(Block letters)	NURSING HOME	
	First Names	MILVYL ROAD	
		LEE ON SOLENT	PO13 9LU
	Date of Birth	19.04.1907	19040707
		DR JH BASSETT	

FIX CONTINUATION MR411 (E) HERE

Date	Time	ONCE ONLY AND PRE-MEDICATION DRUGS	Route	Dose	Signature	Given

AS REQUIRED PRESCRIPTION

Administration Record FIX CONTINUATION MR411 (B) HERE

Date	Time	Dose	Given	Date	Time	Dose	Given	Date	Time	Dose	Given	Date	Time	Dose	Given

Code A

PTO

Page 62 of 714.

Code A

Code A

given on 18.8.98. Baatar does not mention it until the 21.8.98 dehydrates. Baatar does not mention it until the 21.8.98

Page 30 of 714. Beed jumped the gun again Hyozine given 18.8.98 before Baatar's instructions. Hyozine given 18.8.98 not correct.

Times of Sympie driver (from 18.8.98) not correct. Sympie 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 history from the 19.8.98. She can confirm Sympie driver 'replenished' but no note is a file. The times or the amounts given. If Beed gave 40mg in the Sympie driver how much did Joyce give at a different time. P. 63 of 714.

Code A

63 of 714.

How much did Joice administer when she came on & went off duty? Another 40mg or 20mg. Records abnormal. Patient was not drowsy - she was 'out' from 17. 8. 98 after X-ray. She never opened her eyes or shined.

Code A

6

TAKES STEADY OFF A GOOD

REGULAR PRESCRIPTION		Administration Record FIX CONTINUATION MR 411 (C) HERE							
Month	→	APR							
Date	→	11	12	13	14	17	18	21	

PRW

PRW

Code A

PTO

Page 64 of 714.

I find it extremely difficult to read the dates but it
 seems Mac Book Joice and Cowenman game group Discipline
 in the Springs Dinner at? 11.20. 10.45 - 11.00 + Joice game
 more at 1800 1800 a 0800 How much?
 See note on P. 63 of 714?

7

PORTSMOUTH HEALTHCARE NHS TRUST
PROVIDER SPELL SUMMARY

FOR PATIENT'S G.P.

HOSPITAL SITE CODE: GWM

CASENOTE NO: G099198 DISTRICT NO: 130407ZY HOSPITAL: GOSPORT WAR MEMORIAL

SURNAME : RICHARDS

FORENAME: GLADYS

DOB : 13.04.07 MARITAL STATUS: W SEX: F PLACE OF BIRTH:

WARD: DAE

DIAGNOSIS

PREVIOUS NAMES:

Dislocated R Hip

DATE ADMITTED: 11 08 98 RELIGION: CE

CONSULTANT 1: AL SPECIALTY: 4306
DR A LORD

CONSULTANT 2: SPECIALTY:

OPERATION/INVESTIGATION

HOME ADDRESS: GLEN HEATHER N/HOME
MILVIL ROAD
LEE-ON-THE-SOLENT
HANTS

POSTCODE: PO13 9LX TEL NO:

FAMILY DOCTOR: DR J. BASSETT
THE HEALTH CENTRE
MANOR WAY
LEE ON SOLENT

DATE REC'D.	24 AUG 1998
TREATMENT	RECOMMENDATION
COMPUTER	
SHOW TO	
TELL PATIENT	
CONSULTANT	

Code A

10/2/98

PTO.

P 460 7 714.

written by P. Beed (?). My mother did not survive as
the 11.8. 98 report with a dislocated hip. Just how
careless can Beed be?

Code A

8

PORTSMOUTH HEALTHCARE NHS TRUST
PROVIDER SPELL SUMMARY

HOSPITAL SITE CODE: GWN FOR PATIENT'S G.I

CASENOTE NO: 6099198 DISTRICT NO: 130407ZY HOSPITAL: GOSPORT WAR MEMORIA

SURNAME : RICHARDS FORENAME: GLADYS

DOB : 13.04.07 MARITAL STATUS: W SEX: F PLACE OF BIRTH:

WARD: JAE

PREVIOUS NAMES:

DATE ADMITTED: 17 08 98 RELIG:

CONSULTANT 1: AL SPECIALTY:
DR A LORD

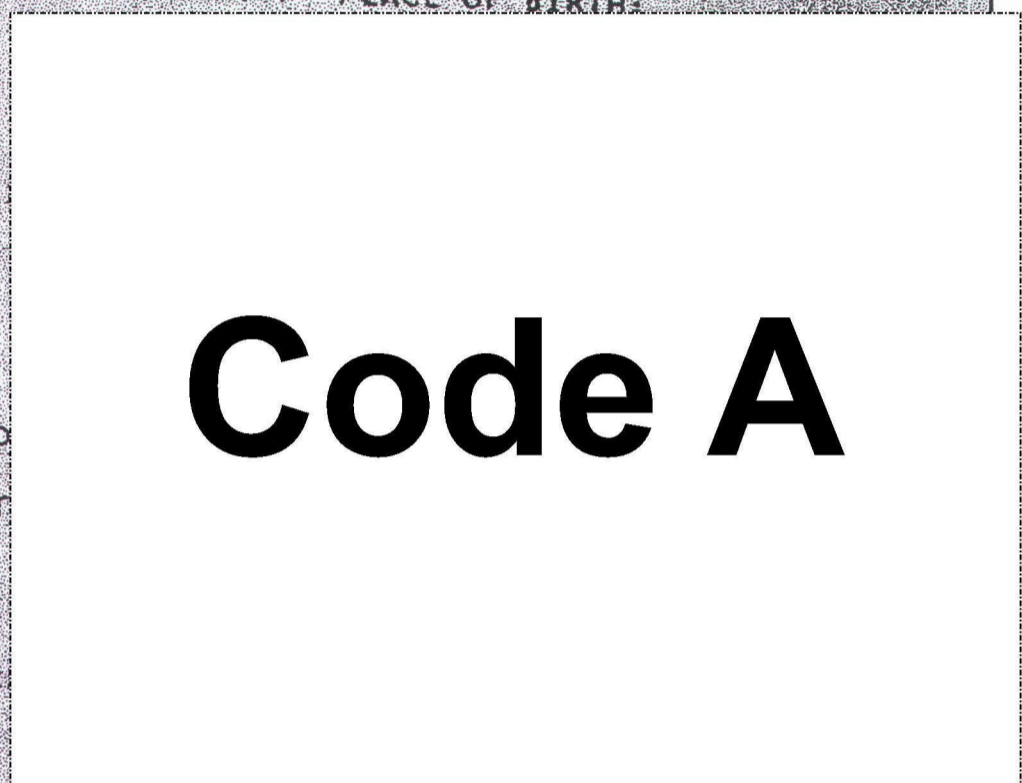
CONSULTANT 2: SPECIALTY:

HOME ADDRESS: GLEN HEATHER M/KO
MILVIL ROAD
LEE-ON-THE-SOLENT
HANTS

POSTCODE: PO13 9LX TEL NO:

FAMILY DOCTOR: DR J. BASSETT
THE HEALTH CENTRE
MANOR WAY
LEE ON SOLENT

GP CODE: R50644



Code A

P.T.O.

P.461 714.

My mother was not admitted on the 17.8.98 with
a diagnosis of ~~pneumonia~~ bronchopneumonia following broken hip.
Nor was treatment of Sympie ~~given~~ given on the
20.8.98. It was set up on the 18th.

It would have been 'normal' in palliative care for the Sympie
driven 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 when
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 think my mother was anywhere near death on

the 17/18 8.98.

Code A

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, Code A 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

DOCUMENT RECORD PRINT

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.

Code A in 24 hour period. Did they raise Yeah. mother to consciousness every 4 hours to giver Code A - Rubbish. See my notes P30 of 714. Decision taken fo Code A 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 Code A Code A 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

DOCUMENT RECORD PRINT

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 lithotpsy (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 (17/08/1998) 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 Code A Code A 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

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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

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DOCUMENT RECORD PRINT

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?

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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).

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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 (18/08/1998) 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.

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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 - Code A 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

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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

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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