MC7

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Code A

From: Williams, David
Sent: 10 October 2008 13:57
To: 'Horsley, David'
Cc: Code A
Subject: FW: Letter Mrs Mackenzie case to HM Coroner.

Attachments: Operation ROCHESTER Policy decision to release from investigation.

Dear Mr HORSLEY..

Apologies for delay in response to the issues regarding the deceased Glady's RICHARDS (Mother of Gillian Mackenzie..)
Hopefully the attached should provide enough material for you to be able to deal with the Mackenzie issues..

Regards..DW.

Point 1.. Investigative failures?..

There are no substantiated complaints of investigative failure.

There have been several complaints from members of the public in respect of the investigation.

I have reviewed the complaints summaries and results are as follows:-

12.09.98.. Incivility during investigation - unsubstantiated.
12.09.98.. Neglect of duty - unsubstantiated.
12.09.98.. Neglect of duty - unsubstantiated.
14.05.02.. Early levels of contact between police and family members fell short of what expected - *substantiated*
27.10.06.. Failure to properly investigate - unsubstantiated.
27.10.06.. Police lied in respect of level of disclosure of material to CPS - unsubstantiated.
27.10.06.. Lack of communication and support to family members - unsubstantiated.

Point 2. Cause of death.

Operation
)CHESTER Policy dec

Relevant extract from Dr Black's statement
Dr Black

SUMMARY OF CONCLUSIONS

Gladys RICHARDS presents an example of a common, complex problem in geriatric medicine. A patient with

Code A

In my view a major problem in assessing this case is poor documentation in Gosport Hospital in both the medical and nursing notes, making a retrospective assessment of her progress difficult. Good Medical Practice (GMC 2001 states that "Good clinical care must include an adequate assessment of the patient's condition, based on the history and symptoms and if necessary an appropriate examination"....."in providing care you must keep clear, accurate, legible and contemporaneous patient records which report the relevant clinical findings, the decisions made, the information given to patients and any drugs or other treatments prescribed". "Good clinical case must include - taking suitable and prompt action when necessary".... "Referring the patient to another practitioner when indicated"...."in providing care you must - recognise and work within the limits of your professional competence"..."prescribe drugs and treatments, including repeat prescriptions only where you have adequate knowledge of the patients health and medical needs". The lack of detail in the medical notes, the absence of evidence of asking for advice on 17th August

and the lack of recording why decisions were made or if the patient was properly examined present poor clinical practice to the standards set by the General Medical Council. In particular, I am concerned the anticipatory prescription of Opioid analgesia on her admission to Gosport War Memorial Hospital. If no justification for this can be identified or proven, then I believe that this was negligent practice and may have contributed to her fall on the ward. I **also believe that the d[Code A]was sub optimally high. However I do not believe this contributed in any significant way to Mrs RICHARDS death and that her death was by natural causes.**

Re Lacks statement

This was taken on 11/08/04 so it was never forwarded to CPS it was not forwarded to Dr Black when he made his statement but her concerns are

Haematoma as the reason to prescribe diamorphine.

In my original statement I refer to **Phillip BEED** **N45** telling me that my mother had developed a massive haematoma and that this was the cause of her pain and the reason for the use of **Diamorphine** **C64** . This conversation took place on Tuesday 18th August 1998 (18/08/1998).
This is in Mrs Lacks first statement and was forwarded to CPS

On 21st August 1998 (21/08/1998) my mother died. I was present at her death and shortly afterwards I and my daughter **Code C** **N74** laid my mother out.

We washed her face and hands and brushed her hair. We then changed her into a clean nightie. In order to change the nightie we had to turn her on to both sides so I had a clear view of her body. There was no sign of a haematoma nor did she have any pressure sores. (This was not mentioned in her first statement) ([Code C] as never statemented nor it appears seen)

There is no mention of haematoma in Dr Blacks statement although in the medical notes he examines he states the following

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

There is no clear reason from the prescribing of the diamorphine which again Dr Black is critical of.

Bronchopneumonia as cause of death.

Dr Black addresses this

There is no doubt that after people have been dying over a number of days, if a post mortem is performed, then secretions and changes of Bronchopneumonia are often found in the lungs as the very final agonal event. This allows clinicians to put the phrase "Bronchopneumonia" on the death certificate. Unfortunately, under current guidance to Coroners if 'fractured neck of femur' is written on the death certificate, then the Coroner has little option but to perform a post mortem as the death is deemed to be non accidental. Where patients have not died immediately after a fractured neck of femur, some Coroner's Officer's encourage clinicians to leave 'fractured neck of femur' off the death certificate to save the relatives the potential trauma of a post mortem. I believe this is poor national practice, but it is not a specific criticism in this case.

From: Williams, David
Sent: 14 August 2008 14:24
To: 'Horsley, David'
Cc: Code A

Subject: Letter Mrs Mackenzie case to HM Coroner.

File note.

Issues highlighted by HM Coroner arising from letter dated 22nd July 2008 from Mrs Mackenzie's solicitors 'Bondman's LLP'.

1. Mrs Mackenzie made complaints upheld by the PCA and IPCC which accepted that there had been investigative failures.

Action.. Supt WILLIAMS to view Professional Standards Dept files next week for detailed outcomes and report to coroner(However ..there were several complaints made but no investigative failings reported since Supt WILLIAMS involvement commencing Sept 2004) All available information was finally reviewed by Dr BLACK and grounds for further criminal investigation were just not there.

2. Mrs Mackenzie was told by Supt WILLIAMS that her mother had not died from pneumonia an expert had concluded that she died from dementia..she does not agree with the cause of death..

Action.. **Code A** *to research medical statements in respect of Gladys RICHARDS cause of death.. Dr BLACKS statement in particular where he comments death natural causes and no discernable negligence*

3. Mrs McKenzie's sisters statement (Mrs LACK) never considered by the CPS - important because of her sisters numerous concerns about her mothers care..

Action. **Code A** *to confirm when Mrs LACKS second statement was taken as who considered it when.. FFW/ CPS/ SIO before NFA determination?*

Mr HORSLEY.. I need to be sure about the complaint outcomes.. Can I get back to you next week re these.. Do not have them immediately available.. They are numerous and I will need to read the papers..

Thanks..Dave WILLIAMS.

Operation ROCHESTER. Policy Decision 17.08.2005.

The Death of Gladys RICHARDS (Category 2)
Decision to release from further police investigaton.

Following the death of 91yr old Gladys RICHARDS at Gosport War memorial Hospital on 21st August 1998 her daughter made an allegation of unlawful killing (grossly negligent care)

A police investigation led to a file of evidence being submitted to the Crown Prosecution Service in the autumn of 1998. In March 1999 the CPS advised that there was insufficient evidence to commence criminal proceedings.

The investigation continued during 1999 and 2000 police commissioning further expert opinion.

A file of evidence was submitted to the CPS in January 2001. Again, after due consideration, the CPS advised the police in August 2001 that there was insufficient evidence to prosecute any individual or body.

In the light of additional allegations in respect of deaths of other patients further expert opinion was commissioned and files of evidence submitted to the CPS in September 2002.

In November 2002 the CPS again advised that was insufficient evidence upon which to base a prosecution.

Operation ROCHESTER a wider investigation into 'unlawful killing claims' commenced in September 2002, ultimately 90 deaths of Gosport War Memorial Hospital patients were and continue to be investigated by police.

All of these cases were reviewed by a multi-disciplinary team of experts in toxicology, palliative, geriatric, general medicine and nursing. Their task was to provide an analysis of the medical records of each of the patients and to categorise each case into 3 separate groups.

The category 1 group contained cases where the treatment provided was considered to be optimal. All have been released from police investigation.

The category 2 group contained cases where the treatment was considered to be sub optimal but not extending to gross negligence to a criminal standard.

The case of Gladys RICHARDS was assessed as a category 2 and at the lower end of that scale ie closer to a one than a three.

All but the category 2 cases of RICHARDS and PACKMAN have been released from police investigation and forwarded to the General Medical Council and Nursing and Midwifery Council for their consideration.

The category 3 group contained cases assessed as 'negligent' in terms of the care provided. It is these cases that continue to be forwarded to the CPS for their ongoing consideration.

The categorisation by the multi-disciplinary team was quality assured by a legal/medico lawyer who also took into account particular concerns raised by deceased family members.

The independent medico legal advisor suggested that in the light of ongoing concerns raised by the daughter of Glady's RICHARDS, Mrs Gillian MacKENZIE that a final expert witness view should be sought in respect of the categorisation.

Medical expert Dr David BLACK reported concerns in respect of the standard of medical and nursing notes, and anticipatory prescription and dosage of opioid analgesia, however it was reported that the expert did not believe that this contributed in any significant way to Mrs RICHARDS death. Dr BLACK added that the patient presented as one with major progressive and end stage pathology (a dementing illness) developing a second pathology (fractured neck of the femur) gradually deteriorating and dying. Whilst the dose of diamorphine prescribed on 17th August 1998 was sub optimally high it did not contribute in any significant way to Mrs RICHARDS death and her death was through natural causes, in his view fractured neck of the femur and severe dementia.

Upon the basis that this case does not fall into the category 3 status there is no justification for further police investigation, accordingly no further police action other than to forward papers to the GMC and NMC will be taken.

This decision will be delivered personally to the daughters of the deceased by the SIO Det Supt WILLIAMS and Dep SIO DI NIVEN. This is the culmination of a seven year police investigation during which Gillian MACKENZIE in particular has been passionate in the raising of a multiplicity of concerns surrounding the investigation. The SIO considers a personal visit and explanation of the decision entirely appropriate under these circumstances.

D.M.WILLIAMS Det Supt