MG11(T)



HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

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

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Marilyn Ann JACKSON

Age if under 18:

(if over 18 insert 'over 18')

Occupation:

Senior Care Assistant

This statement (consisting of 4 page(s) each signed by me) is true to the best of my knowledge and belief and I make it knowing that, if it is tendered in evidence, I shall be liable to prosecution if I have wilfully stated in it anything which I know to be false or do not believe to be true.

Signature:

M A Jackson

Date:

30.04.02

I am a senior care assistant at Solent Cliffs Nursing Home, Hill Head, Fareham. I have been involved in the caring profession for the past five years, with particular emphasis on the care of the elderly. I have first hand experience of the needs of patients and the levels of care they can expect to receive in their circumstances. Communicating with relatives and families of those patients is also an important aspect of my work.

On 21 August 1998, my mother, Mrs Alice WILKIE, died whilst being treated as a patient of the Gosport War Memorial Hospital. I had serious concerns about her care and treatment, so much so, that in April 2001 I contacted the police to request that they open a criminal enquiry into the events surrounding her death. I now understand that the police have concluded their enquiry and intend to take no further action in this matter. My family and I are wholly unsatisfied with this outcome and it has left us to come to our own conclusion. We wish to finally resolve this matter, but are unable to, as several key questions – as outlined below – have not yet been addressed. I feel that the police should be able to answer these issues and I will not be satisfied until they have done so. I have been given a copy of the medical notes which were completed during my mother's stay at the Gosport War Memorial Hospital in August 1998. I refer to them by the mark MAJ – 1.

| Signed: | Signature witnessed by: | |
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MG11A(T)(cont.)



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Continuation of Statement of : Marilyn Ann JACKSON

These notes contain a number of discrepancies which to this date have not been adequately accounted for.

Amongst many observations, I consider the following issues to be the most serious:

- a) The notes are marked DNR, which I understand to mean 'Do not resuscitate'. Why was this recorded without any reference to the family?
- b) It appears that entries on Mrs WILKIE's notes also have incorrectly entered recordings from a patient called Gladys RICHARDS. Some of these entries have 'entered in error' recorded on them.

 What were the circumstances which led to this confusion?
- c) There are two times of death recorded on the notes, 1830 and 2120. I believe the 1830 entry is the 'correct' one, but why were two times recorded and with this confusion how can we be sure as to the accuracy of the 1830 timing?
- d) There appears to be a considerable gap between the initial entries made on 10.8.98 and 21.8.98 (the time of death). What clinical care occurred between those dates?

The above issues are in themselves, matter for concern and refer, in the main, to procedural issues, but my overwhelming observation is that the final stages of her treatment leave a great deal of unanswered questions.

On 17th August 1998, sometime in the early evening, I went to the Gosport War Memorial Hospital, where I met the ward manager, Philip BEAD. He was responsible for the ward that my mother, Mrs WILKIE, was on. He informed me that my mother's health was deteriorating and that she wouldn't have long to live. I was surprised and shocked at this news, because less than two weeks earlier, she had come to the hospital, merely to be assessed and recuperate from a previous urinary infection. Although she was 82 and had some dementia, she was and had been physically well prior to

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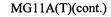
the urinary tract infection. I was not expecting this news. Throughout my mother's stay at the hospital I had called to see her every day and it is fair to say that I was far from impressed with the level of care she received.

On Thursday 20th August 1998, at around 12.30pm, I was at the hospital and I had spoken to my mother and ascertained that she was in some discomfort. I then attempted to get someone to come and assess her condition. No one was available for over an hour and eventually Philip BEAD came to my mother's bedside, where I outlined my concerns. He said that 'they' would give her something to make her comfortable; she would be very sleepy, but still able to hear us. I then left to go to work and phoned my daughter, Lisa PAYNE, and asked her to go to the hospital to check on my mother's condition.

Around 8pm that same day, I returned to the hospital and found my mother totally unconscious. I saw that she now had a syringe driver administering a drug to her. I now know, having read her medical notes, that this was applying Diamorphine in 30mg doses to her. Until this point I was unaware of any painkillers of any kind being given to my mother. As a senior care assistant, I am aware that 30mg of Diamorphine, is a very large dose to be applying to anyone, but especially when nothing else has been given previously. This raises a number of serious issues. Firstly – who authorises and prescribed the administration of the diamorphine? Why was it regarded as necessary and what assessment had been made to reach that conclusion? I regard this dose of diamorphine as being far too great for a woman such as my mother and I would like to know how much this contributed to her death.

In the absence of any other documentation from some inadequate medical notes, I have been left to conclude that the administering of the diamorphine was used deliberately to hasten the death of

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my mother. Whilst I have not had any further explanation, other than the cause of death being pneumonia and dementia (I had seen <u>no</u> physical symptoms for pneumonia) I can only conclude that this was a deliberate act by someone at the hospital.

Together with my family, I am requesting that someone provides some answers to the questions and issues raised in this statement. I am aware that very similar allegations surrounding patient care at the hospital have been made by people in a similar position to myself. M A Jackson.

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