

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 [redacted] Code A [redacted] 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 UTL, 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

Code A

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