Complaint into the treatment/death of Mrs GR

46. It all started with the complaint into the treatment of GR who was 101 years old and who died on Deadalus Ward in August 1998. I have a copy of the associated complaint file and have used this to help construct this statement (although I suspect this file copy may be incomplete.).

47. The history was that GR had fallen at the nursing home where she lived, broken her hip and been taken to Royal Hospital Haslar where a half hip replacement was carried out (a hemi-arthroplasty). She was then transferred to Daedalus ward at GWMH for rehabilitation. Two days after arrival she was found lying on the floor beside her chair and a dislocated hip was diagnosed by x-ray. She was sent back to Haslar to have her hip manipulated back into place, under anaesthetic. It took her a while to come round from the anaesthetic and she stayed at Haslar for 48 hours before being transferred by ambulance back to Daedalus ward.

48. When GR was brought back onto the ward she was screaming in agony. The ambulance staff transferred her from a trolley onto her bed, using a draw sheet because no trolley canvas was available at Haslar. Usual practice is to make such transfers using a canvas and poles. She was subsequently diagnosed with a haematoma (collection of blood) in the hip. It was felt that it would be unsuitable for this to be dealt with by surgery, because that would have meant a third operation in a short period of time and she had not recovered terribly well from the last operation.

49. There were concerns that she would not survive a third operation. It was felt that the best course of action was to keep her pain free, and after discussion with both of her daughters she was started on diamorphine via a syringe driver. It was recognised that with the trauma history and haematoma, at her age it would be difficult for her to recover.

50. Before she died the Healthcare Trust received a complaint from one of GR's daughters who raised concerns about pain management, the fall and her general care.

51. A complaint file was started and arrangements were made for an investigation to be carried out. Barbara Melrose, who worked for me, usually handled complaints from this geographical area. But I took the initial telephone call from the daughter and remained in contact with the complaint at various stages, although Barbara was managing it. Subsequently, and with the benefit of hindsight I don't feel that the

investigation was as thorough as it could have been. No one at Haslar or the ambulance service was asked for comments about how GR came back to GWMH from Haslar screaming in pain.

52. A few weeks later GR's second daughter (GM) telephoned the manager who had carried out the investigation, asking for a copy of the correspondence with the first daughter . GM stated that her sister would not tell her the detail of her complaint because of a family feud. However, the first daughter did consent to us sharing this information with her sister.

53. A meeting was offered to the first daughter to discuss her concerns, and subsequently GM asked to attend too but unfortunately she was not able to attend the date that had been arranged. We asked the sisters to identify alternative suitable dates when they could both attend, and then contact us with this information so that the meeting could be re-arranged. This took place at the end of September 1998. Unfortunately the sisters did not contact the Trust again about a date for the meeting and nobody from the Healthcare Trust contacted them about this either.

54. This was where the formal complaints process ended – the last entry in the complaint file about the proposed meeting was dated 30th September 1998.

The Police investigations

55. It is my understanding that the police have undertaken a total of three investigations into the deaths at GWMH.

56. I first became aware that the police were investigating on 11th December 1998 when Code A from Gosport Police Station telephoned me. He told me that GM had asked the police to bring a charge of "unlawful killing" against the doctor in charge of GR's care. Her concern was that the doctor had "failed to give nourishment" via a drip whilst a syringe driver was being used, therefore causing GR's death. He told me that he had already taken a statement from a Macmillan Nurse, Barbara Davis. Code A Code A said that he needed to decide what action to take, if any. He said he felt that the matter was about a clinical decision and therefore not a police matter. He said that he would like a statement from the Trust plus a copy of the medical notes regarding the use of a syringe driver, and details of the information given to the family at the time.

57. Code A also told me that he had been in contact with the GMC who had asked him to write to them explaining that the charge comes from GM, and not the police.