Code A

MM/BM/YJM

22nd September, 1998

4378

Dear Code A

I am writing further to my letter of 25th August, 1998 now that I have received the report from Mrs. Hutchings, who has been investigating all the matters you raised concerning the care provided for your mother, Mrs. G. Richards, prior to her death on Friday, 21st August, 1998.

I should like to reiterate how very sorry I am that your grief has been compounded by so many concerns, but that you for having taken the trouble to write, as this has resulted in a very thorough investigation, and given us the chance to explain and/or apologise for the problems you identified. It has also meant that staff have reviewed procedures and improvements are being implemented as a result.

I should like to respond to each of the points you made, using the numbering system from your notes.

1. At what time did Mrs. Richards fall?
   She fell at 1330 on Thursday, 13th August, 1998 although there was no witness to the fall.

2. Who attended her?
   She was attended by Staff Nurse Jenny Brewer and Health Care Support Worker Code A

3. Who moved her and how?
   Both members of staff did, using a hoist.

4. After the fall
Your mother had been given medicationi presecribed by Dr. Barton, who was present on the ward just after her fall. I understand that it was not your wish for your mother to be given stronger medication because it made her drowsy.

5. Why was there such a delay in dealing with the consequences of the fall?
With the benefit of hindsight it is possible to assume that your mother's dislocation could have been identified much earlier and we can now only apologise for that delay if that was the case. It is notoriously difficult to establish degrees of pain or discomfort in dementia sufferers, but staff now recognise that more attention should have been paid to your mother's signs of discomfort, and your own expressed concerns about that.

6. Why no x-ray? Why no transfer?
These delays were a direct result of the failure to identify a problem earlier in the day - because the x-ray department at Gosport War Memorial Hospital only operates from 9 a.m. to 5 p.m. I understand that you did appreciate this when it was discussed with you on the Thursday evening, and agreed with the advice that it would be best to defer a transfer to Haslar until an x-ray based diagnosis had been made. The transfer to Haslar was organised as soon as possible after the situation had been confirmed by x-ray, on the morning of Friday, 14th August, 1998. It is a matter of great regret that this delay occurred, and we accept and apologise for the fact that the standard of care fell below that which we aim to provide.

7. Why when she was returned to bed from the ambulance was her position not checked?
When your mother arrived on the ward two health care support workers saw her into bed and then went to inform Staff Nurse Couchman that your mother had arrived. They had realised there was a problem and that professional advice was needed. Staff Nurse Couchman came and checked her position, and I believe you assisted her in straightening your mother's leg and placing a pillow between her legs.

8. (a) How was she brought from Haslar?
She was brought by an ambulance with two crew.

(b) Was there an escort/anyone in the back with her?
There was no nurse escort - this would have been arranged by Haslar had it been thought necessary.

(c) When did she start to show pain and what caused it?
The ambulance crew commented that she showed signs of being in pain as she was put into the ambulance. The cause of the pain has not been specifically identified.

(d) Why was my request to see the x-rays denied?
The x-rays were seen in the x-ray department by the doctor and the consultant radiologist. The decision to keep x-rays in the department and not to send them to the ward rests with the consultant radiologist, not the ward staff, and your request may not have been relayed to the department.

(e) Decision to do nothing but provide pain relief?
Dr,. Barton felt that the family had been involved at this stage as she discussed the situation fully with you. She made sure you were aware that the surgical intervention necessary for the haematoma would have required a general anaesthetic and clearly your mother was not well enough for such a procedure to be undertaken. Therefore, the priority, and only realistic option, was to keep her pain-free and allow her to die peacefully, with dignity.

9. Clothing sent for marking despite being named already
As a result of previous problems the ward have adopted the practice of marking all patients clothing with the ward name - a procedure designed to help, which on this occasion, did the absolute opposite. The laundry marker at Gosport War Memorial Hospital had broken down, so your mother's clothes were sent to St. Mary's Hospital and meanwhile she was given hospital clothing. In attempting to meet your completely reasonable request for her own clothes to be returned, a taxi was authorised which in the event brought the clothes back - still only bearing your mother's name. Whilst, as you say, this was a trivial problem on the scale of the real issues, it was a quite ridiculous consequence of a well-intentioned policy which served to cause unlooked for stress. The process is being reviewed as a result of your complaint.

All the staff concerned with the care of your mother were deeply saddened at her experience, and sincere apologise are proffered to you and your sister for the problems which occurred, and the failure of the service to meet your very reasonable expectations. The only constructive aspect I can identify is that lessons have been learned and the experience will benefit future patients, although I fully appreciate that such benefits have little relevance to yourselves.

You may be aware that your sister, **Code A** has telephoned Mrs. Hutchings as she wishes to see this correspondence. I am writing to her to confirm that it is personal to you, although, of course, I hope that you will feel able to share it with her. If you unable to do this then she will need to raise a complaint of her own.

/continued - page 4

Should you wish to pursue the matter further my secretary would be very happy to arrange a meeting with Mrs. Barbara Robinson, Hospital Manager, at your convenience and I would be grateful if you could contact her on 01705 894378 within one month should you wish this.

Thank you once again for writing so comprehensively of your concerns.

Yours sincerely,

Max Millett
Chief Executive

Silent copy to: Mrs. B. Robinson
Mr. W. Hooper

(1)

Ref Gladys Richards DOB 13 4 98 fmH.
Died 21.8.98

Tuesday 11th Aug. Admitted from Haslar. Able to walk - painfree. No Analgesia necessary!
Wednesday 12. Dementia mis-read. Diamorphine given - (knocked off) so no funds etc could be given. Thought her dementia was Pain!
THURSday 13 Aug.
Seen to be in pain by Granddaughter. Code A 1.30 - 2.15pm
Brought to ward staffs attention. Thought to be dementia, Mr Hotter showing with pain, great pain in her hip. (For your info. she is a Code A brought to the attention of the staff that Mum had qualified Nurse) LH.

(1) At what time did Mrs Richards fall?
(2) Who attended to her.
(3) who moved her and how.
(4) I arrived and saw My mother was in pain. Anxious expression, weeping - calling out. I spoke to several trained and untrained staff. I was told - there is nothing wrong - its her dementia. I asked had she seen a Doctor? I was told she had fallen from her chair. Could she be Xrayed? At supper time while my mother was quiet and I was reasoning her some soup I was asked "Do you think your Mother is in pain?" by RGN doing the drug round. "Not at the moment while I'm feeding her?" I said "Well you said she was in pain". "Yes" I said "she has been very uncomfortable" since I got here". "Do you think she has done some damage?" "No" "she only fell on her bottom from the chair" I stayed till 7.45pm My mother was in distress throughout.

At 9.30pm. I received a phone call from the ward. "When we put your Mother to bed she was in great pain and she may have done something. The Doctor feels its too late to send her to Haslar and our Xray unit is closed. We will give her diamorph for the night to keep her painfree and Xray here in the morning."

(5) This was an avoidable delay. Why? Any lay person could have seen she was hurt - by the angle of her leg & thigh. LH.

FRIDAY 14th. I arrived as she was taken to Xray.

FROM : GOSPORT WAR MEMORIAL HOSPITAL +0705 580360 : +0705 580360 Aug. 24 1998 11:27AM P02

(2)

She was deeply under with a/a morph.
She was Xrayed. The movement caused pain and I stayed with her to comfort her.
We returned to the ward. I was called in to the office by Philip - ward manager and DR Barton to be told - "Your worst fears of last night appear to be true. We have rung Haslar and they have accepted her back."
We arrived at Haslar late morning - mid day. She was expected. The ambulance was bleeped. We saw Hollie in Casualty immediately. We then saw DR. He showed me the Xrays and position of limb - which I had seen in G.W.H - 24 hrs from accident to admission and second emergency operation. Why? Why no examination? Why no xray? Why no transfer?
(6)
She arrived at Haslar and within 1hr had a manipulation to put the hip back in the socket. From then she was pain free.
She did not regain consciousness fm 1am (15th) on Sat 15th due to amount of analgesia required for the procedure. She was then catheterised so that there was no need to move slippi pan. She had a drip as she had had NIL BY MOUTH since before Xrays on 14th.
She remained pain free in full length leg splint both legs level and straight - shown to me by consultant. No analgesia was required - she was able to use a commode for the toilet and weight bare for transfer. She ate and drank and the drip was removed and her fluid balance was acceptable.
She progressed on Sunday and was easily manageable. She was seen early a Monday 17th when transfer back was recommended. I rang Haslar at 8.30am to be told she would be going A.M. I asked if I should come & pack & accompany her and they said "No need

FROM : GOSPORT WAR MEMORIAL HOSPITAL DENISE KIN +0705 580360 : +0705 580360 Aug. 24 1998 11:28AM P03

(3)

She is fine" I went to G.W.H about 10.45am and was told the ambulance was due about midday I arrived back at 12.15 mid day
On entering through the swing doors to the ward I heard my Mother screaming. On arrival to the room a care assistant said "You try feeding her I can't do it she is screaming all the time" My Mother had a staring anxious expression She was gripping her Rt thigh op site tightly. She uttered the words Do Something Do something the pain the pain - don't just stand there - I don't understand it the pain the pain sharp sharp — this is some adventure. A SRN came into the room at all the noise I moved the sheet and said look at the awful position she is in, she was lying awkwardly towards the left side with the full length splint not straight and the hips uneven. She cried in pain. I said to the RGN "can we please move her" We moved her together with our arms together under her lower back and the other around her thighs we placed the squarty on her buttocks and within minutes she stopped the screaming

(7) Why when returned to bed from the ambulance was he position not checked?
why was the source of pain not sought?
From 1pm onwards the Charge Nurse Manager frequently checked my Mother. He acknowledged our concern. He acknowledged her obvious pain. We asked for X rays We asked what had happened between leaving Hasler & arrived into her bed at G.W.H. It was acknowledged that "Something" had happened

FROM : GOSPORT WAR MEMORIAL HOSPITAL DUNNE KIN +0705 580360 : +0705 580360 Aug. 24 1998 11:29AM P04

(4)

The charge nurse was concerned for her pain and analgesia was given 3 times between her admission & 6pm.

Phillip's ward manager agreed she needed Xray to establish if damage had been done as had occurred to the hip.

Xray Dept refused forms signed PP for the DR who was unavailable

An appointment for Xray was made for 3.45pm as the DR called was expected at about 3.15pm The charge Nurse did all he could to expedite this - keeping us informed and continually checking Katies obvious severe pain. He administered pain relief in readiness for the Xrays. He was courteous and attentive at all times.

DR Barton arrived and we left the room as asked She examined my Mother. She stated she did not think there was further dislocation but the Xray would go ahead. A review would be held later when Xrays had been seen

We went to Xray. My mother was in pain despite her pain relief. I was not allowed in with her as I was the previous week. I could hear her wailing through the doors while the Xray plates were put in place. We returned to the ward. We were told there was no dislocation but obviously something had happened. We were told she would be given Oramorph for the pain & fully through the night for pain relief and reviewed in the morning.

On Tues 18 we arrived on the ward and were told she had had a peaceful night. We were told that she had a massive haematoma causing pain at the Op sit.

FROM : GOSPORT WAR MEMORIAL HOSPITAL DUNNE NO +0705 580360 : +0705 580360 Aug. 24 1998 11:30AM P05

(5.)

and the plan of management was to use a syringe driver to ensure she was pain free and she would not suffer when she was washed - moved or changed should all become inconvenient.

The outcome of the use of a syringe driver was explained to us fully. We agreed.

A little later DR Barton appeared and confirmed that a haematoma was present and that this was the kindest way to treat her. She also stated "and the next thing will be a chest infection". Totally insensitive to those already in the final stages of bereavement. Because the syringe driver was essential following the administration of analgesia for pain - my mother of course would not now regain consciousness, speak, open her eyes to see us, or hear anything anymore. To us Mother as we know her is already gone.

(8) How was she brought from theatre? Was there an escort? Was anyone in the back with her? When did she start to show pain? What caused it? I request again to see the last X rays. Why decisions were made to do nothing but allow to die painfully.

Answers to the numbered questions are sought in detail.

Trivial things added to our trauma. Her clothing already cash's name tabs marked - had all gone the day after her admission for marking - despite my agreeing to do the washing daily.

Asking continually, to insisting today that Mother be allowed to wear her own clothes has resulted in them being brought by Taxi from 5 days 8 days later - still unmarked and all totally unnecessary - as was a staff Nurse yesterday asking to have her day clothes away - "because we get them up here you know". Our reply was - Just look at her - she will not be getting up anywhere.

The contents of events in this report were in the majority witnessed by my elder sister.

Code A

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