Enclosure TB.01/11.56

STRICTLY CONFIDENTIAL

Portsmouth HealthCare NHS
NHS Trust

Complainants: Mrs. L. Lack (daughter) - original complaint
Mrs. G. McKenzie (daughter) - subsequent approach to police alleging unlawful killing

Patient: Mrs. G. Richards (mother)

Admitted: 11th August, 1998 (Daedalus Ward)
◊ Frail, confused, deaf, Alzheimer's, agitated, deteriorating mobility with history of falls. Admitted from nursing home to Haslar with fracture, transferred to Gosport War Memorial Hospital for slow rehabilitation.

Died: 21st August, 1998

Complaint: 19th August, 1998 (Mrs. Lack)
◊ Events surrounding Mrs. Richards' fall.
◊ Transfer for x-ray to and from Haslar.
◊ Decision to treat palliatively.
◊ Clothing.

11th December, 1998 (Mrs. McKenzie): Trust hears indirectly through a telephone call from the police that Mrs. McKenzie is alleging unlawful killing.

Outcome: Trust response to Mrs. Lack's complaint due to be discussed at meeting with family on 29th September, 1998, but that meeting was cancelled by Mrs. McKenzie. Then overtaken by the allegation of unlawful killing.

Allegation of unlawful killing investigated by police, and their investigation sent to Crown Prosecution Service. In July 2001 the latter decided not to pursue and closed the case.

Background Information:
◊ Summary in letter to Commission for Health Improvement of 15th August, 2001 (without attachments).
◊ Trust response (22nd September, 1998) to Mrs. Lack's original complaint.

MM/YJM/31.10.01/g:people:max:tboard:richards.doc

Ms Margaret Tozer
Investigations Manager
Commission for Health Improvement
11th Floor, Finsbury Towers
103 Bunhill Row
London
EC1Y 8TG

Our ref: MM/DH
Your ref:
Date: 15 August, 2001
Ext: 4306

Dear Margaret

RE: GOSPORT WAR MEMORIAL - POLICE INVESTIGATION INTO THE DEATH OF GLADYS RICHARDS

Further to your recent telephone conversation with Mrs Humphrey, I enclose a chronological summary of events (as requested by Dr Patterson) from the time of Mrs Richards admission to Gosport War Memorial Hospital up to the present date.

You may already be aware that the CPS have recently decided to close this case, as there is insufficient evidence to proceed.

The attached summary concentrates on what happened to Mrs Richards and the subsequent family complaint and police investigation. You are probably also aware that the South East Regional Office, the Department of Health, the General Medical Council and the United Kingdom Central Council have taken an interest in this case. However, we have not included details of communications with them in this summary.

This was a complex case from the outset, with family disharmony affecting communication at many stages. Attached to the chronological summary, as appendices are:

a) The hand-written notes of concern from Mrs Lack, Mrs Richards daughter.

b) My formal reply to the points that she raised.

c) A report prepared by Dr Lord, for the first police investigation.

continued..../

You will see that Mrs Lack's concerns and questions, as brought to our attention at the time, related to the events surrounding Mrs Richards unwitnessed fall, when her hemi-arthroplasty was dislocated; and her transfer to and from R.N Hospital Haslar following this fall.

Mrs Lack's notes (last page, 6th line from the top) record that she and her sister Mrs Mackenzie agreed with the decision of palliative care only, following Mrs Richards final return from Haslar Hospital.

The main actions arising from this complaint were clarification of the informal policy on transferring patients to Haslar Hospital, out of hours. As you will see from Dr Lord's report, there has never been a formal policy on not transferring patients out of hours. The decision will be made on the basis of clinical need, and where appropriate, patients will be transferred at any time of the day or night.

The issue of palliative care, rather than active treatment and, the use of syringe driver analgesia was not part of the original complaint raised with the Trust. Indeed at that time we understood that the family were in agreement with the clinical decisions made towards the end of Mrs Richards life.

In the subsequent police investigations it became clear that interest was being expressed in the use of syringe driver analgesia, and in particular the broad prescribing practice of Dr Barton. As there was no resident medical cover at Gosport War Memorial Hospital, it was important that prescriptions for pain relief offer sufficient flexibility to avoid excessive pain levels whilst a doctor is called to change a prescription, but staying within the bounds of safety of administration.

Dr Barton's practice was to prescribe Diamorphine 20/40mgs - 200mgs, subcutaneously via a syringe driver, over 24 hours. Her prescription for Mrs Richards was 40mgs - 200mgs in 24 hours, Mrs Richards was only ever given 40mgs in 24 hours.

Since this complaint, a number of changes in policy and medical cover have been made:

(a) Policies on both Prescription Writing and The Assessment and Management of Pain have been reviewed - copies enclosed for your information.

(b) The daytime medical support formerly covered by a GP Clinical Assistant is now covered by a staff Grade post. (Note: out of hours cover remains with a local GP Practice).

The past few years have been very difficult and stressful for the staff concerned in this case. We are anxious to focus on any positive outcomes and would be very willing to participate in a Commission for Health Improvement review of any of the issues arising from this case. We would be particularly interested in exploring palliative versus active treatment decisions, in circumstances such as these and likewise the use/method of delivery of analgesia when palliative care decisions are made. All the guidance supports close family involvement in decisions such as these - the clinical team feel that they met this aim, yet they later faced the potential of criminal charges.

continued..../

We look forward to hearing from you in the future. It has been difficult to decide on the level of detail to supply here. Please do not hesitate to contact Lesley Humphrey again (023 92 286970) if you should require further information.

Yours sincerely

Max Millett
Chief Executive

Enc.

Portsmouth HealthCare NHS
NHS Trust

GWMH POLICE INVESTIGATION

Chronological Sequence of Events

Background

GWMH is a community hospital where the day to day care is provided by a team of nurses, therapists and managers. The medical care, except on the GP wards, is overseen by a designated consultant, depending on the ward speciality, who conducts weekly ward rounds. At the time in question, the day to day medical care on Daedalus ward was provided by Dr Barton, a local GP, acting as clinical assistant and making daily and on request visits to the ward. There is no resident medical cover and out of hours cover is provided by a local GP practice.

The nursing care provided is non-acute. Daedelus Ward has 24 beds, eight for people needing slow stream stroke rehabilitation and 16 for those who met the criteria for NHS continuing care. Mrs Richards was a continuing care patient.

Patient

Mrs Gladys Richards
D.O.B Code A
D.O.D. 21st August 1998

Previous resident of Glen Heather's Nursing Home, Millhill Road, Lee On Solent

Past Medical History:-

Deaf in both ears
Cataract operations to both eyes
Alzheimer's (confused for some years)
Confusion/agitation worse for last 6 months
History of falls/deterioration in mobility over last 6 months
Hysterectomy 1955

30th July 98	Fall at nursing home, fractured neck of femur. Admitted to E6 Ward Haslar Hospital where right hemi - arthroplasty was performed.
3rd August 98	Reviewed by Dr Reid: recovering fairly well from surgery although mobility limited and clearly confused. To transfer to GWMH for opportunity to try to re-mobilise.
11th August 98	Transferred to Daedelus Ward, GWMH for slow mobilisation. Consultant Althea Lord; Clinical assistant Dr Jane Barton (local GP)

Condition on transfer

Wound healed, pressure areas intact. Needing total care, washing, dressing, eating, drinking etc. Occasional incontinence at night. Full weight bearing, but walking with the aid of two nurses and a zimmer frame.

13th August 98

13.00hrs - Mrs Richards found on floor by chair checked by Staff Nurse Bryant, no apparent injury, hoisted into another chair.

18.30hrs - Daughter Mrs Lack visited and informed of fall. Nursing reports/records differ from the observations made by Mrs Lack in her note of complaint (see appendix A). Nursing reports were of no obvious signs of pain or injury. Mrs Lack notes that both she and a granddaughter observed Mrs Richards to be in pain and reported this to the nurses, who replied that it was her dementia that was the problem.

19.30hrs - On being helped into bed, right hip noted to be internally rotated and Mrs Richards to be in pain. Dr Briggs, duty doctor (local GP) contacted. He advised analgesia over night, with x-rays at GWMH in the morning, on the basis that transfer to Haslar Hospital at that time of night would be too traumatic for Mrs Richards. Daughter, Mrs Lack, informed.

14th August 98

10.45hrs - x-rayed at GWMH; Mrs Lack present. Dislocation of right hip confirmed. Transferred to Haslar Hospital by ambulance with nurse escort.

Closed relocation of right hip hemi - arthroplasty, under I-V sedation at Haslar Hospital. Reduction uneventful but rather unresponsive following sedation; gradually more responsive but catheterised as unable to pass urine. Canvas knee immobilising splint applied to discourage further dislocation.

17th August 98

11.45hrs - Returned from Haslar in an ambulance with no nurse escort and no trolley canvas for lifting (Note: transport arranged by Haslar Hospital). Very distressed on arrival, crying out in pain, but stopped when positioned in bed.

13.05hrs - Again in pain. Mrs Lack concerned. Dr Barton contacted. X-ray ordered.

15.45hrs - Hip x-rayed: Film seen by Dr Peters and radiologist; no dislocation seen. For pain relief overnight and to be reviewed by Dr Barton in the morning.

18th August 98

11.15hrs - Reviewed by Dr Barton, for pain control via syringe driver. Dr Barton met with Mrs Lack and Mrs Mckenzie and explained that a haematoma had formed at the site of surgery/manipulation.

Dr Barton's clinical opinion was that Mrs Richards was not well enough for further surgery and that she should be kept comfortable and pain free.

	Dr Barton believed that Mrs Lack and Mrs Mckenzie agreed with this decision and this is confirmed in Mrs Lack's notes of complaint. Diamorphine 40mgs and Haliperidol 5 mg and Midazolam 20mgs (this was the dosage given until Mrs Richards death) commenced via syringe driver, over 24 hours.
19th August 98	Mrs Lack telephoned Lesley Humphrey, Quality Manager at Trust Central Office to express concerns. Arrangements made for her to see Sue Hutchings, Nurse Co-ordinator on the ward.
20th August 98	Mrs Lack put her concerns in writing for Sue Hutchings (see appendix A)
21st August 98	**21.20hrs** - Mrs Richards died peacefully, with her two daughters Mrs Lack and Mrs Mckenzie present.
25th August 98	Formal letter of acknowledgement of complaint sent to Mrs Lack from Max Millett, Chief Executive.
8th September 98	Mrs Mckenzie telephoned Trust Central Office requesting copies of correspondence between Mrs Lack and the Trust. She said that she and her sister were not on speaking terms.
22nd September 98	Formal letter of response to complaint from Max Millett, Chief Executive to Mrs Lack with offer of a meeting to discuss complaint and findings, Mrs Lack agrees for a copy to be sent to Mrs Mckenzie
24th September 98	Mrs Lack telephones to request meeting.
25th September 98	Letter from Max Millett, Chief Executive, to Mrs Lack and Mrs Mckenzie confirming meeting arrangements for 29th September at GWMH, with Barbara Robinson.
28th September 98	Mrs Mckenzie telephoned Trust Central Office to say she could not make the meeting on 29th September. She would arrange another date with her sister and telephone again.
2nd October 98	Letter from Max Millett, Chief Executive, to Mrs Lack and Mrs Mckenzie saying we are awaiting a further date from them for the planned meeting.
11th December 98	Telephone call from DC Madison of Gosport Police Station to say that the police have been asked by Mrs Mckenzie to investigate a charge of unlawful killing of Mrs Richards, by Dr Barton. Mrs Mckenzie says nourishment was not given via a drip, whilst syringe driver used.
22nd December 98	Dr Lord prepares a statement for the police on request regarding the care provided for Mrs Richards at GWMH. (Appendix C).
19th January 99	Letter from Max Millett, Chief Executive to DC Madison, enclosing report from Dr Lord.
24th February 99	Trust advised that case with the C.P.S

17th March 99	Message from DC Madison to say that the CPS had reviewed this case and that there was insufficient evidence to justify a prosecution.
7th October 99	Telephone message from DCI Ray Burt, to Max Millett stating that he will be writing soon about access to Gladys Richards records.
11th October 99	Max Millett, Chief Executive, receives a letter from DCI Burt to say that this police investigation has been re-opened.
19th October 99	Lesley Humphrey, Quality Manager has a telephone conversation with DCI Burt . Mrs Lack complained that the earlier police investigation was inadequate. On examination this had proved to be so. The police would now have to conduct a very thorough investigation; the charge would be unlawful killing.
27th October 99	Lesley Humphrey meets with DCI Burt, who explains the process to be followed
January/February 00	Medical records and police findings reviewed by Professor Livesey for the police.
Spring/Summer 00	Portsmouth HealthCare Trust staff assist police with investigations. Mrs Richards' medical records and x-rays are handed over to police. Dr Barton, Dr Lord and a number of nursing staff are interviewed by the police.
September 00	Professor Livesey again asked to review case notes.
January 01	Police case sent to the CPS for decision.
April 01	Press stories published about this police investigation. Nine other families approach the police with concerns about the death of a member of their family at GWMH.
June 01	DS John James takes over the case from DCI Ray Burt.
6th July 01	Letter from DS James to Max Millett, Chief Executive requesting the release of the health records of four other people who died at GWMH in 1998. Following the press stories and subsequent contact made with the police by members of these families the local police wish to undertake preliminary enquires into these four other cases but only to reassure themselves that there is no need for any further investigation.
20th July 01	CPS decide that there is insufficient evidence to proceed with Mrs Richards case. The case is closed.
8th August 01	Four sets of records collected from Trust Central Office by the police.

GOSPORT WAR MEMORIAL PERSONNEL

Dr Althea Lord	Consultant Gerontologist
Dr Jane Barton	Clinical Assistant

(Local GP contract to work as clinical assistant 9 - 5, Monday to Friday. Out of Hours cover provided by Dr Barton's GP Practice on call system)

Dr Ian Reid, Consultant Gerontologist and Trust Medical Director

Staff Nurse Brewer — Daedalus Ward ? Grade

Dr Briggs, GP providing out of hours cover, from Dr Barton's GP Practice

Dr Peter, GP providing out of hours cover, from Dr Barton's GP Practice

Sue Hutchings	Nursing Co-ordinator/acting Service Manager (covering annual leave)
Barbara Robinson	Service Manager

Mrs. L. Lack,

Code A

MM/BM/YJM

22nd September, 1998

4378

Dear Mrs. Lack,

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

2. <u>Who attended her?</u>
   She was attended by Staff Nurse Jenny Brewer and Health Care Support Worker Cook.

3. <u>Who moved her and how?</u>
   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.

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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