Investigation of Complaint made by Mrs Lesley Lack
Re: Standard of Care Received by her late Mother - Mrs Gladys Richards
whilst Patient on Daedalus Ward Gosport War Memorial Hospital

Complaint made verbally to Lesley Humphrey - Director of Quality followed by written notes of events forwarded to myself on 21st August 1998.

Following discussion with Mr Bill Hooper - I was asked to commence investigation on 24th August 1998.

Commissioning Officer - Mr W Hooper
Investigating Officer - Mrs Sue Hutchings

Investigation commenced: 24th August 1998
Investigation completed:

1. Background

2. Analysis of Events

3. Conclusion

4. Recommendations

5. Statements taken during the investigation

   5.1 S.N Margaret Couchman - September 3rd 1998

   5.2 S.N Jenny Brewer - September 3rd 1998

   5.3 Clinical Manager Philip Beed - September 8th 1998

   5.4 E.N Monica Pulford - September 8th 1998

   5.5 S.N Christine Joice - September 9th 1998

   5.6 HCSW Code A - September 10th 1998 (telephone statement)

Other Documents

6. Accident Report Form

7. Riddor Form

8. Code A Notes

1. Background

Mrs Gladys Richards
D.O.B. Code A
Died 21.8.98

Mrs Richards was admitted to Daedalus Ward Gosport War Memorial Hospital from Haslar Hospital on Tuesday 11th August 1998 following hemi-anthroplasty for fracture Rt neck of femur; this had been sustained as a result of a fall while Mrs Richards was a resident at Glen Heather's Nursing Home. Mrs Richards did suffer from degree of dementia but was walking with the aid of a zimmer frame and 2 nurses pain free; not requiring any analgesia when she was discharged from Haslar.

Wednesday 12th August 1998. Mrs Lack felt her Mother's dementia was mis-read by nursing staff - although Mrs Lack stated her Mother was able to communicate when she needed to go to the toilet, or when she was in pain. For some reason (not made clear to Mrs Lack) her Mother was given oramorphine - which caused Mrs Richards to become very drowsy and unable to take any fluids. At this point Mrs Lack suggested to nursing staff, she thought her Mother was in pain - but was told it was her dementia that was causing her Mother to cry and scream. On 13th August 1998 about 5 pm Mrs Lack was informed by Staff Nurse - her Mother had fallen earlier in the day.

It was a further 24 hours before diagnosis of dislocation of Rt hip was confirmed.

Mrs Lack has raised the following questions, which the investigation will focus on:-

1. At what time did Mrs Richards fall?

2. Who attended to her?

3. Who moved her and how?

4. Mrs Richards in pain, anxious, crying - calling out - told by trained and untrained staff "nothing wrong" - why?

5. Avoidable delay in being seen by Doctor and X-Ray ordered - why?

6. Why not transferred sooner?

7. Transfer back from Haslar to Gosport War Memorial Hospital? - leg not positioned correctly - not checked by trained nurse - source of pain not identified?

8a. Was there a nurse escort from Haslar - was anyone accompanying Mrs Richards in the back of the ambulance.

8b. When did Mrs Richards begin to show signs of being in pain and what caused it?

9. Why was Mrs Lack not allowed to see X-Rays and not involved in making decision "to do nothing" - allowed to die pain-free.

10a. Mrs Richards personal clothing - identified by cash's name tags all sent for "marking" day after 1st admission - despite Mrs Lack agreeing to do the washing daily - why?

10b. No clothes sent with Mrs Richards to Haslar.

10c. Following Mrs Lacks insistence on her Mother wearing her own clothes and asking where they were, discovered they were at Laundry at St Mary's Hospital - returned to Daedalus - once taxi was ordered by nursing staff - still unmarked - why?

ANALYSIS OF EVENTS

Mrs. Gladys Richards was a frail, 91 year old with dementia who had sustained a fracture of her right neck of femur whilst resident in a Nursing Home. She had surgical repair at Haslar Hospital. Despite her age and confused mental state Mrs. Richards made a good recovery and the medical team at G.W.M.H. agreed to accept Mrs. Richards to give her the opportunity for mobilisation. The transfer to Daedalus Ward was arranged and took place on **11.08.98.**

On arrival to Daedalus Ward, Mrs. Richards was quiet and accompanied by her daughter, Mrs. Lack. She was admitted by Enrolled Nurse Pulford and Mrs. Lack was seen and told of the plan for managing her mother whilst on Daedalus. Mrs. Richards was also seen by Dr. Barton and medication was prescribed.

Wednesday 12th August, 1998.

S/N Joice was on a late shift. She went into Mrs. Richards room and became concerned because Mrs. Richards looked poorly. She was very drowsy and pale in colour although sitting in a chair. When Mrs. Lack visited later that afternoon she also became very concerned about her mother's drowsy condition. She was informed of the medication her mother had been given. Mrs. Richards was transferred back to bed by use of a hoist. This did cause Mrs. Richards to wake up and cry out. She settled and was fed her supper by Mrs. Lack

Thursday a.m. 13th August, 1998.

The Ward was very busy with general activities plus two admissions expected and two discharges. Staffing levels were low although the Clinical Manager had taken some steps to ensure adequate level. There was only one trained nurse on until 12.15 p.m. and after 3.30 p.m. with Consultants round due at 2.00 p.m.

Mrs. Richards had been got up earlier in the morning and sat in a chair in her room. After lunch, approximately 13.30 hours, an H.C.S.W. found Mrs. Richards on the floor by her chair. S/N Brewer was informed and she immediately attended to Mrs. Richards. She checked for any injuries. At this point she did not feel any had been sustained so authorised Mrs. Richrds to be put back into a safer chair using a hoist.

Mrs. Lack was due to visit that afternoon so S/N Brewer made the decision to see her rather than telephone her regarding her mother's fall, particularly as she did not appear to be suffering from any injuries. It was 6.30 p.m. when S/N Brewer spoke to Mrs. Lack and informed her of the fall, explaining she did not know how she fell but reassured Mrs. Lack she had checked her mother before moving her. At this point S/N Brewer asked Mrs. Lack if she thought her mother to be in pain. Mrs. Lack did not feel she was as she was eating her tea.

At 7.45 p.m. S/N Brewer commenced putting Mrs. Richards to bed. Once in a lying position she could see Mrs. Richards (right) hip was internally rotated. The Duty Doctor was called immediately and informed of the problem, patients age and dementia. The Duty Doctor felt it would be too traumatic to transfer Mrs. Richards overnight, but to give pain relief and arrange x-ray at G.W.M.H. the following morning and to contact him if any further problems arose.

Mrs. Lack was telephoned as soon as the pain relief had been administered (approximately 8.30 p.m.) and informed of the current situation and Doctor's advice. S/N Brewer asked if she was satisfied with this to which Mrs. Lack replied "Yes" and thanked S/N Brewer. Mrs. Richards slept well that night.

Friday 8.00 a.m. 14th August, 1998

Dr. Barton visited the Ward and completed X-Ray Request Form. Mrs. Richards was taken to X-ray Department about 10.45 a.m. accompanied by Mrs. Lack. X-ray confirmed dislocation of (right) hip. Mrs. Lack was seen by Dr. Barton and Philip Beed, Clinical Manager, and informed. Arrangements made for transfer to Accident and Emergency, Haslar. Mrs. Richards was given pain relief prior to transfer and was accompanied by H.C.S.W. in the ambulance (Mrs. Lack followed in her car). Mrs. Richards remained at Haslar for 48 hours and arrangements were made to transfer back to Daedalus Ward on 17.08.98.

Monday 11.45 a.m. 17th August, 1998

Mrs. Richards arrived on Daedalus Ward. Mainline Ambulance Crew, but no nurse escort. Transport was arranged by Haslar who telephoned Daedalus and apologised they could not find a canvas to put Mrs. Richards on, i.e. canvas would have two poles inserted to lift patient. Instead they used two sheets to lift Mrs. Richards who was crying and screaming, which apparently had started in the ambulance and continued for some time after her arrival.

Two H.C.S.W.'s supervised Mrs. Richards being put into bed. The ambulance man stated he had been given strict instructions from Haslar that Mrs. Richards was to be kept flat - in bed she was given two pillows only and a pillow between her leg. H.C.S.W. Baldacchino was very concerned regarding the position of (right) leg. She was afraid to straighten it because of the noise Mrs.Richards was making so went to find a trained nurse and seek her advice. At that point Mrs. Lack arrived. S/N Couchman walked into the room and pulled back the covers and realised the leg was not positioned correctly. Mrs. Lack offered to assist S/N Couchman and between them re-positioned Mrs. Richards who then stopped screaming.

Mrs. Richards became agitated again a little later. Mrs. Lack requested her mother be x-rayed again. Dr. Barton was contacted and agreed . S/N Couchman was asked to complete X-ray Request Form and p.p. it. Unfortunately, X-ray Department refused to accept the form and insisted a Doctor's signature had to be on the form. Surgery was contacted and Duty Doctor signed the form and faxed to G.W.M.H. All of this did cause delay.

Mrs. Richards was x-rayed at 15.45 hours. Films were seen by Consultant Radiologist who confirmed no further dislocation. Dr. Barton was informed and discussion took place with Clinical Manager and both Mrs. Richards's daughters who were informed a haematoma had developed at the site of manipulation, i.e. (right) hip and, in medical opinion, the best treatment would be to keep her pain free. The use of a syringe driver was discussed fully. Both daughters agreed to this course of action. From 18th August - 21st August Mrs. Richards condition deteriorated and she died at 8.20 p.m. on the 21st August. Both daughters were present.

All trained staff interviewed were very aware that Mrs. Lack and her sister, Mrs. McKenzie, did not agree between themselves regarding their mother's care, particularly about pain control. This did make the nursing of Mrs. Richards difficult at times, i.e. she was not returned to bed following her fall on 13.08.98 as Mrs. Lack had complained previously she felt her mother was on her bed too much and this would not help with rehabilitation.

During her last day of life Nursing Staff were prevented from removing Mrs. Richards dentures as part of mouth care as the daughters said they were not to remove them.

Nursing staff reluctantly accepted this, although in hindsight agree they should have tried harder to persuade the daughters it was in their Mother's best interest to remove the teeth for cleaning.

Sadly, Mrs. Richards's death was not as Mrs. Lack had hoped it would be. She felt the use of the syringe driver made her mother become unconscious and she did not say her "goodbye", although both she and her sister were with their mother almost continuously day and night during Mrs. Richards last few days. Nursing staff tried not to be obtrusive.

Note 2

CONCLUSION

Mrs. Richards did fall from her chair on 13.08.98 but this was not witnessed by anyone. The trained nurse on duty at the time did check her for injuries and there did not appear to be any. Therefore, Mrs. Richards was put into another chair with a table to help prevent reoccurrence. Unfortunately, on that day the Ward was exceptionally busy and low in numbers of trained staff, although patient care did not suffer - only the stress level of the one trained nurse. Mrs. Lack stayed with her mother until early evening and was asked if she felt her mother to be in pain. Mrs. Lack did not feel her mother was. Mrs. Lack was then asked if she would like her mother to be put to bed. She replied "No rush".

Once S/N Brewer put Mrs. Richards on the bed, using a hoist, she noticed the angle of the hip and immediately phoned the Duty Doctor. Medical opinion was not to transfer to x-ray until the following day.

When did dislocation occur, i.e. when she fell? or when hoist was used?- unable to define.

Once x-rays confirmed dislocation, transfer to Accident and Emergency at Haslar was arranged - as appropriate.

In view of Mrs. Richards' previous fracture I feel she should have been transferred to Haslar the night before and that S/N Brewer should have insisted on this when contacting the Duty Doctor. S/N Brewer did agree with the Doctor that transferring Mrs. Richards at that time, i.e. 8.30 p.m. - 9.00 p.m. would have been too traumatic for Mrs. Richards. You could argue, due to Mrs. Richards's dementia, would she have been aware of the time?

Haslar Hospital were responsible for organising transport to transfer Mrs. Richards back to Daedalus Ward. It appears they booked Main Line Ambulance Services who were not happy about transferring Mrs. Richards without a canvas to lie her on. Haslar apologised and gave them two sheets instead. The Ambulance Crew confirmed to the nursing staff that Mrs. Richards began crying/screaming immediately they put her into the ambulance. They were given instructions to keep her flat. This may have been the cause of Mrs. Richards' distress or pain due to the transfer from bed to trolley to bed at Daedalus.

A nurse escort did not accompany Mrs. Richards. Unable to confirm the position Mrs. Richards was in in the ambulance, but once in bed it was noted her leg was not straight but at an angle. This would have caused some considerable discomfort. Once her (right) leg was straightened, within a few minutes of arrival she stopped crying out.

Once further x-rays confirmed no further dislocation, medical, nursing and family were involved in making the decision of how to treat Mrs. Richards - in view of Mrs. Richards age of 91 years. Agreement was made that she must be kept free of pain, therefore syringe driver was put in situ to ensure continual pain relief, the outcome of which was explained fully to both daughters.

Sadly, Mrs. Richards last few days and her death were not how her daughters had hoped her end would be, i.e. she did not regain consciousness and they felt they could not say "goodbye". The nursing staff were very aware of this and tried to involve the family as much as possible. Regarding the "trivia" part of the complaint, i.e. clothing being sent away for marking. It is policy on Daedalus Ward for all patient's clothing to be marked with the Ward name. This decision has been made in the light of complaints from relatives whose clothing has disappeared. This includes clothing of patients whose relatives agree to their laundry. It is a safeguard in case an article of clothing is put into the Hospital Laundry Bag by mistake. Unfortunately, at the time Mrs. Richards was admitted the marking machine at G.W.M.H. was broken so the laundry lady sent it to St. Mary's for marking but failed to inform the Ward of this. Steps have now been taken to ensure Wards are kept informed.

The nursing staff are sorry that this added to the stress the family were already suffering. As a result of this investigation an action plan will be recommended by myself to ensure we reduce the risk of further complaints of this nature.

RECOMMENDED ACTION PLAN (to be agreed with Service Manager)

1. Review agreed "policy" of medical consultant team not to transfer patients to Accident and Emergency, Haslar outside of working hours (i.e. G.W.M.H. X-Ray Dept.).

2. Review nursing records and documentation.

3. Further training on records and documentation for all staff.

4. Review marking of clothing "policy".

Code A

11/9/98

Witness Statement: Mrs Margaret Couchman - Staff Nurse Daedalus Ward.

The following statement was taken by Mrs S Hutchings - Investigating Officer on 3rd September 1998.

Q1. Can you confirm you were the named nurse for Mrs Gladys Richards?

A. Yes

Q2. Did you complete the admission documentation on 11th August 1998.

A. No - not on duty - EN Pulford was responsible for completing the admission documentation.

Q3:1 Can you explain why Mental Test Sheet was not completed as Mrs Richards was diagnosed with dementia?

Q3:2 Can you explain why Lifting/Handling Risk Calculator Form was not completed?

A3:1) No
A3:2) No - I did not complete the admission documentation - but agree this should have been completed.

Q4. Were you on duty at the time Mrs Richards was found on the floor?

A. No.

Q5. Were you on duty when Mrs Richards was transferred back from Haslar Hospital?

A. Yes.

Q6. On arrival on the Ward, did Mrs Richards appear to be in any discomfort?

A. I was at coffee break at time of her arrival, but on my return I went into Mrs Richards room and introduced myself - I noticed Mrs Richards was in some distress and not positioned correctly - Mrs Lack offered to help me move her Mother - informing me she was a retired nurse, we straightened her, placed a pillow in between her legs - she immediately appeared more comfortable. I cannot be certain if she had a splint - I think she probably did.

Q7. When moving Mrs Richards with her daughter - did you notice any swelling around the hip?

A. No - Mrs Richards held her hand on her hip and said "it hurt".

Q8. Was she accompanied by a nurse from Haslar.

A. I cannot answer, I was not on the Ward at the time of Mrs Richards arrival.

Q9. How was Mrs Richards pain controlled?

A. Oramorph 10 mgs 4 hourly - given orally.

Q10. Was her daughter involved in making this decision?

A. After Mrs Richards was settled, the daughter tried to feed her Mother (HCSW took meal away to "mince") as Mrs Richards could not cope with "lumps". Mrs Lack felt her Mother was still in pain and she told me that the Surgeon at Haslar had said if the hip dislocated again - it was to be replaced. Pain controlled discussed with Mrs Lack - who was reluctant for her Mother to be given medication, but did eventually agree. Dr Barton contacted and advice sought - X-Ray form written and signed by me i.e. pp. By Dr Barton, but this was not acceptable to X-Ray Dept. - who insisted form must be signed by Doctor new form was faxed to Surgery and signed by Duty Doctor. Mrs Richards was X-Rayed at 15.45 hours.

Q11. Why would her clothing be sent for marking at the Hospital when her family had agreed to do her washing?

A. Not necessary, but I am aware Gosport War Memorial Hospital had run out of labels i.e. "Daedalus Ward", therefore it was sent to St. Mary's to be labelled.

Q12. Were you aware of the family's concerns regarding the standard of care their Mother was receiving?

A. Yes - the family told me in no uncertain terms.

Q13. It there anything else you would like to say?

A. After the syringe driver was commenced and Mrs Richards appeared more peaceful - the family's attitude appeared to change towards the staff.

Witness Statement: Mrs Jenny Brewer - Staff Nurse Daedalus Ward

The following statement was taken by Mrs S Hutchings Investigating Officer on 3rd September 1998.

Q1. How long have you worked on Daedalus Ward as 'D' grade Staff Nurse?

A. Since December 1996.

Q2. Did you have any involvement in the care of the late Mrs Gladys Richards?

A. Yes on Wednesday 13th August 1998 I was on late shift and after 15.30 hrs - the only trained nurse on duty. I was not the named nurse for Mrs Richards.

Q3. Where you on duty when Mrs Richards had a fall?

A. Yes.

Q4.1 Can you describe what happened and the action you took.

A. See attached statement.

Q4.2 Can you explain why you did not fully complete the Accident Form?

A. As I was busy with Dr Lord - a colleague completed some of the details for me and I signed it - I admit I did not complete all the details and Philip filled in parts that had not been completed.

Q5. Did you ask the Duty Doctor to visit Mrs Richards?

A. Dr Barton was on the Ward and was aware; as Mrs Richards did not appear to have suffered any injuries - I did not ask her to examine Mrs Richards. The Duty Doctor was contacted by telephone after 19.45 hrs when I noticed the internal rotation of Mrs Richards Rt hip.

Q6. How would you describe Mrs Richards mental state while she was on Daedalus Ward?

A. I am aware she suffered from dementia - but she was not my patient.

Q7. Did you speak to Mrs Lack (Mrs Richards daughter) on the day of the fall?

A. Yes - when she visited tea-time approximately I was completing the medicine round. I did not telephone her immediately after the fall as I felt it better to see her face to face.

Q8. What did you say to her?

A. I informed her that her Mother had fallen from the chair earlier, but she did not have any apparent injuries.

Q9. Were you on duty for the evening drug round?

A. Yes.

Q10. Did you ask Mrs Lack if she thought her Mother was in pain?

A. Yes. Mrs Lack's reply was "not at the moment I am feeding her" - it was at this point I informed her of her Mothers fall. After this Mrs Lack did say her Mother was in pain (see Question 19).

Q.11 Who put Mrs Richards to bed that evening?

A. Myself and HCSW put Mrs Richards to bed at 19.45 hrs using hoist. At this time - I noticed the Rt hip to be internally rotated and painful. At 2000 hrs contacted Duty Doctor Dr Brigg and informed him I thought the hip to be dislocated - see statement.

Q12. Did you have any further involvement with Mrs Richards after the day of the fall?

A. Yes - only very little - she was not my patient.

Q13. Were you on duty when Mrs Richards was transferred back from Haslar?

A. No - I was a day off. I next saw Mrs Richards on Tuesday 18th August 1998 - I was on a late duty i.e. 12.15 pm - 9 pm (see attached).

Mrs Lack spoke to me whilst I was in the sluice, she was angry - telling me that her Mother "was walking yesterday at Haslar - she is here today and dying". My response was sympathetic - said I was sorry and maybe the journey from Haslar had upset her.

Q14. Were you aware of the disappearance of Mrs Richards clothing?

A. No.

Q15. Were you aware that the family agreed to do her washing?

A. Not aware - as Mrs Richards was not my patient.

Q16. Were you on duty on 19th August 1998?

A. Yes.

Q17. Did you ask the family to take Mrs Richards clothes away?

A. No.

Q18. Were you aware of the family's concerns regarding the standard of care their Mother received?

A. Yes.

Q19. Do you have anything else to say?

A. Yes - concerning Mrs Lacks account of events, page 1 Mrs Lack refers to speaking to trained and untrained staff - there was only 2 trained staff on duty - S.N Joice and myself - I was completing the Consultants Round and I would not have blamed the dementia as a cause for Mrs Richards distress.

I did ask Mrs Lack if she thought her Mother to be in pain, she responded by saying "no - I am feeding her". At this point I did inform Mrs Lack that her Mother had had a fall - I had not previously phoned her as I wanted to see her face to face. After I informed her of her Mother's fall - she sought me out (I was still doing the medicine round) and informed me her Mother was in great pain. I told Mrs Lack I would come back and make an assessment with Mrs Richards on the bed - Mrs Lack asked me not to put her on the bed.

At this point - an emergency occurred with another patient and as the only trained nurse on - I had to attend. I did not want HCSW putting Mrs Richards to bed, so it was not until 19.45 hrs that I was able to put Mrs Richards to bed and that was when I noticed the internal rotation of the Rt leg.

Witness Statement: Mr Philip Beed - Clinical Manager Daedalus Ward

The following statement was taken by Mrs S Hutchings, Investigating Officer on 8th September 1998.

Q1. How long have you been Clinical Manager on Daedalus Ward?

A. 18 months.

Q2. Were you on duty when Mrs Richards was admitted from Haslar Hospital on 11th August 1998?

A. Yes - I spoke to Mrs Lack at some length and explained Plan of Care. For 30-60 mins. Mrs Richards was very calm/relaxed - 15 mins. after being seen by Dr she began to cry out. I was unable to differentiate between pain/dementia - I gave her dose of Oramorph - which settled her. I informed daughter of my actions, who appeared pleased with what I did. I did find difficulty in Mrs Lacks approach to pain control, at times she appeared in agreement - other times she didn't

Q3. Were you on duty day of Mrs Richards fall 13th August 1998?

A. No - but the day before - I realised the Ward was going to be busy due to overall activity, admissions, discharges (a) I booked an additional HCSW for a.m. shift (b) Identified 3 patients that could remain in bed (c) Made everyone (all staff) aware it was going to be a busy day.

Q4. On the following day what did you do?

A. I assessed Mrs Richards for myself - she appeared to be pain free (having Oramorph the night before). Dr Barton was present - decision made to X-Ray, we also informed Dr Lord and sought her advice - she agreed with our action plan. I organised the X-Ray after Dr Barton had signed the form. I booked the X-Ray as soon as department opened. Mrs Richards was X-Rayed mid-morning.

Q5. Can you explain why there was a delay in Mrs Richards being seen by a Doctor following her fall - particularly as she had previously had # neck of femur?

A. I believe Mrs Lack is referring to the delay the night before. It is agreed between medical and nursing team, that if accident occurs outside of X-Ray Dept. hours - we would ensure patient is free of pain and referred ASAP the following day - obviously each patient is assessed individually and agreement reached with patients and relatives.

Q7. Would you agree/disagree, that a trained nurse should have observed the angle of her leg to have been abnormal especially as she was in so much pain/distress.

A. Yes.

Q8. Can you please describe what happened when Mrs Lack was called into the office to be seen by yourself and Dr Barton following X-Ray of Mrs Richards.

A. Dr Barton had spoken to Consultant at Haslar who agreed to take Mrs Richards back for manipulation rather than surgery. This was explained to Mrs Lack, booked Paramedic Ambulance, notified A & E and said we would take Mrs Richards back when ready. I asked Mrs Lack if she would like to accompany her Mother to Haslar. Mrs Richards given dose of Oramorph. There was approximately 1 hr delay for Ambulance. I did not feel this delay would cause any adverse effect to Mrs Richard's condition. A HCSW accompanied Mrs Richards.

Q9.1 Why was Mrs Richards not examined following her fall?

9.2 Why a 24 hr delay from fall to admission to Haslar?

9.3 Why was an X-Ray not arranged sooner?

A.9.1 Injury not apparent at time - I found it difficult to distinguish Mrs Richards cries from wanting the toilet or in pain.

9.2 See answer to Q6. (5)

9.3 See answer to Q6.

Q10. Were you on duty on the 18th August 1998 when Mrs Richards returned from Haslar?

A. I was on a late duty that day.

Q11. When were you made aware of the apparent pain and discomfort Mrs Richards was in?

A. At the same time that Mrs Lack became aware. Sequence of events not as Mrs Lack written. S.N Couchman received Mrs Richards and put her into bed. HCSW Jean Moss attempted to feed Mrs Richards lunch - which she didn't appear to want - S.N Couchman advised her to mince the meat. Mrs Lack arrived while Mrs Richards being fed - but Mrs Richards was not screaming at this time. Mrs Richards began to become distressed at the time of Mrs Lacks arrival. Mrs Richards had not been in any distress/pain - if she had - we would have given her some analgesia. The whole situation became very "tense" - Mrs Richards screaming very loudly, both daughters very agitated and worried about another dislocation, this made the situation difficult to handle.

Q12. Can you confirm the family asked for further X-Rays of Mrs Richards hip?

A. Yes - they felt Mrs Richards hip had dislocated again.

Q13. Can you explain the problems with X-Ray Department?

A. Dr Barton contacted and she requested X-Ray Form to be completed. Form was pp - but would not be accepted. Dr Beasley was Duty Doctor who agreed to fax form - booked X-Ray - daughters informed at all times.

Q14. Are family relatives usually allowed to see X-Rays?

A. This would be dependent upon Radiographer in X-Ray dept. - the X-Rays were not forwarded to the Ward - seen by Radiologist in dept.

Q15. Can you recall how long from admission to examination by Dr Barton.

A. 3 hrs. approx.

Q16. Were the family involved in the decision making for pain control and use of syringe driver?

A. The decision to use syringe driver was made after a course of time, discussed with both daughters, this was one option offered - oral analgesia could be continued on 18th August. Medical opinion - by Dr Barton, was that a syringe driver would be the best way of controlling the pain - I explained fully the purpose of using a syringe driver and they both agreed.

Q17. Were you aware that following Mrs Richards first admission to Daedalus, her clothes - already with Cash's name tags, had been sent for marking?

A. Policy for all patients clothing to go for marking at Gosport War Memorial Hospital - unfortunately on this occasion the machine was not working, so they were sent to St Mary's but laundry lady - did not inform us of this.

Q18. Were you aware of the family's agreement to do their Mothers laundry?

A. Yes - but I would still want clothing to be marked - I did explain this to Mrs Lack.

Q19. Can you give any explanation why their request for their Mother to wear her own clothes - was not carried out?

A. They had been sent for marking.

Q20. Were you aware of the family's concerns regarding standard of care for their Mother?

A. Yes.

Q21. Did you or Dr Barton have any discussion with the family regarding "feeding" Mrs Richards during her last four days of life (to include I/V fluids)?

A. I do not remember specially talking about feeding/fluids apart from giving a drink if Mrs Richards woke up. The family did not raise this as a concern at the time.

Q22. Do you have anything else to add?

A. We did find nursing Mrs Richards difficult at times - due to the difference of opinion between both daughters regarding management and pain relief of their Mother.

Witness Statement taken from Monica Pulford Enrolled Nurse Daedalus Ward

The following statement was taken by Mrs S Hutchings - Investigation Officer on 8th September 1998.

Q1. Please state your role/grade and how long you have worked on Daedalus Ward.

A. Enrolled Nurse - 'D' grade - many years.

Q2. Were you involved in looking after Mrs Gladys Richards?

A. Yes. On day of admission spoke to Mrs Lack - checked her surname generally chatted - Mrs Richards was quiet. During supper she (Mrs Richards) asked to pass urine, so we helped her use commode - she was "weight bearing".

The following day I was on early shift - I feed Mrs Richards her breakfast (in dining room) she became "fidgety" - a sign she needed to pass urine - along with another member of staff, we took Mrs Richards to the toilet - I do not recall any further problems during my shift.

Q3. You admitted Mrs Richards on 11th August 1998 and completed the documentation?

A. Yes - most of it.

Q4. Can you explain why the section for "Pain" was not completed?

A. No - negligent of me not to have done so.

Q5. Can you explain why the section for Mental Study was not completed?

A. I was advised by Clinical Manager to leave, it would be addressed later.

Q6. Can you explain why the section for Lifting/Handling Risk Calculator was not completed?

A. I was advised by Clinical Manager to leave, it would be addressed later.

Q7. Were you on duty when Mrs Richards had her fall?

A No - I was a day off.

Q8. Were you on duty on 17th August 1998 when Mrs Richards returned from Haslar?

A. No - I came on duty later at 3.30 pm Mrs Lack was not there - Mrs MacKenzie was with her Mother who had been given oramorph. Philip and I made Mrs Richards comfortable about 2.15 pm she became quiet and settled. Mrs Lack came back into room and kissed her Mother and woke her up again - she became very noisy and distressed. Mrs Richards had been crying/screaming for most of the afternoon.

Q9. Did you have any further involvement with Mrs Richards?

A. No.

Q10. Were you aware the family had agreed to do Mrs Richards laundry?

A. I am not sure.

Q11. Do you have anything else you wish to say?

A. No - as I only work part-time - I did not have much involvement with the family.

Witness Statement of S.N Christine Joice - Staff Nurse Daedalus Ward

The following statement was taken by Mrs S Hutchings Investigating Officer on 9th September 1998.

Q1. Please state your grade/role and length of service on Daedalus Ward.

A. RGN 'E' - 5 years on Daedalus.

Q2. Did you have any involvement with Mrs Gladys Richards?

A. Yes - giving her medication - not involved in any personal care - I work primarily on the Stroke Team - I do not have much involvement in continuing care patients - see statement attached.

Q3. On Mrs Richards return from Haslar on 17th August 1998 did you admit her?

A. No - I saw her arrive on stretcher with ambulance crew - I was at Nurses Station.

Q4. Can you recall which Ambulance Service brought Mrs Richards in and was there a nurse escort?

A. It was Mainline Ambulance - and there was not a nurse escort.

Q5. How was Mrs Richards transferred from stretcher to bed?

A. I do not know - I was not involved - two HCSW assisted.

Q6. Did you attend Mrs Richards during this time at all?

A. No - S.N Couchman returned from coffee break and went into Mrs Richards.

Q7. Did you have any further involvement with Mrs Richards that day?

A. No.

Q8. Please describe Mrs Richards condition on the 18th August 1998?

A. I was on late shift - I saw Mrs Lack leave Mrs Richards room crying and walking towards Activities Room - I followed her - she was very angry and upset and implied I was not telling her everything - I tried to reassured her this was not true.

Q9. Did you give Mrs Richards any fluids whilst you were on duty during 18th August or 21st August 1998?

A. No.

Q10. Did the family ask any questions regarding feeding or giving fluids.

A. No.

Q11. Were you aware the family wished to do the laundry for Mrs. Richards?

A. No.

Q12. Do you remember making any comment to daughters regarding the need for clothes "as we get patients up here" when Mrs Richards was obviously so poorly?

A. No - I couldn't imagine any of the staff making any comment about getting patient up when they were so obviously very poorly.

Q13. Do you have anything further to say?

A. No.

Statement: S.N. C Joice - S.N Daedalus Ward

On the 12th August 1998 - late duty - not met Mrs Richards before - but concerned about her because she looked drowsy: she was pale in colour. I checked her drug chart - she had been given Oramorph at 6 am and Haloperidol.

About 5 pm Mrs Lack visited Mrs Richards - she expressed her concerns regarding her Mothers condition/drowsiness. I informed her of the medication she had been given - reassured Mrs Lack I would inform Doctor if she deteriorated. I asked HCSW to put Mrs Richards into bed - a hoist was used - she woke up and began to cry out. Mrs Lack assisted her Mother with her supper (soup). Mrs Richards continued to be very noisy - but I was very reluctant to give any further medication due to Mrs Lacks concerns; eventually she settled and went to sleep - no further problems for the remainder of shift.

On 13th August 1998 - I was on early shift - Night Staff reported Mrs Richards had been noisy all night - I commenced the Drug Round - I attempted to give her the Haloperidol - she screamed and pushed it away - so it was not given. I asked the HCSW to let me know when they had got her up. I would give her medication then - this time she took the medicine. I was the only trained nurse until 12.15 pm - when S.N Jenny Brewer came on duty - I gave her a report on all patients. I then completed admission process on new patient and Jenny commenced medicine round.

I cannot remember who told me that Mrs Richards had slipped out of her chair - or what time. I did not follow up the report of the fall - as I understood S.N Brewer had dealt with her. I now realise I should have checked her.

I do not recall going into Mrs Richards room during the afternoon up to 3.30 pm when I went off duty; I cannot remember if she was making any noise.

Friday 20th August.
Mrs Hutchings.

Please find herewith some notes I have written and added to our file past 24hrs. I have retained the original.

If you feel you need any clarification please do not hesitate to contact me. or my daughter Code A

I have included all matters relevant as I see it.

Code A RGN

LESLEY LACK

Code A

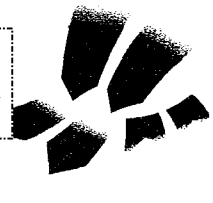
Code A

24/6/97

Bill

As promised - copy of RLS Lack's notes. I have faxed a copy to Lesley Humphrey today.

Code A



(1)

Ref Gladys Richards DOB Code A
Died 21.8.13 JRH.

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

(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 - it's her dementia. I was then told she had fallen from her chair. I asked had she seen a Doctor? Could she be Xrayed? At supper time while my mother was quiet and I was feeding 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 the 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 ovamorph for the night to keep her pain free 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 LL.

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

(2)

She was deeply under with oramorph.
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 Hasler and they have accepted her back."
We arrived at Hasler late morning - mid day. She was expected. The consultant was bleeped. He saw Hollie in Casualty immediately. He then saw me. 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
(6) no xray? why no transfer?
She arrived at Hasler 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 (ish) on Sat 15th due to amount of analgesia required for the procedure. She was then catheterised so that there was no need to move slippy 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 bore 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 Hasler 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

(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 - dont just stand there - I dont endestand 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 her squarly on her buttocks and within minutes she stopped the screaming.

(7) Why when returned to bed from the ambulance was her 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 Haslar & arrival into her bed at G.W.H. It was acknowleged that "Something" had happened

(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 constantly checking Mothers 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

(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 informed 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 first stages of bereavement. Because the syringe driver was essential for having the right 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 Hadar? 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 when decisions were made to do nothing but allow to die pain free.

Answers to the numbered questions are sought in detail.

Trivial things added to our trauma. Her clothing already each's name tabs marked. - had all gone the day after 1st admission for marking - despite my agreeing to do the washing daily.

Asking ~~continually~~ convincingly, to insisting today that Mother be allowed to wear her own clothes has resulted in them being brought by Taxi from St Marys 8 days later - still unmarked and all totally unnecessary. - as was a staff Nurse yesterday asking to take 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~~ and events in this report were in the majority witnessed by my elder sister Mrs Mackenzie.

Lesley Hoole

Comm/Host (6)

Mrs. L. Lack,

Code A

LH/YJM

25th August, 1998

4026

Dear Mrs. Lack,

Thank you for telephoning me last Wednesday, 19th August, 1998, to explain your concerns about the care provided for your mother, Mrs. Gladys Richards, on Daedalus Ward at Gosport War Memorial Hospital. I understand that she died on Friday. This will be a very sad time for you and your family, made worse by the traumatic events of last week. I would like to offer our condolences to you and your family.

I understand that following our telephone conversation, Mrs. Sue Hutchings visited you on Daedalus Ward (covering for Mrs. Barbara Robinson, Service Manager, who is currently on leave). I had intended to capture the details of our telephone conversation in this letter. Events, however, overtook me and I now have a copy of your hand-written report, describing what happened and asking some very logical questions. There seems little point in repeating these in detail here.

An investigation has already begun within our formal complaints procedure. The enclosed leaflets explain how the NHS complaints procedure works, and the future options open to you.

Mr. Max Millett, Chief Executive, will write to you in more detail when our investigation is complete, in about three to four weeks time. In the meantime please let me know if I can be of any further help.

Yours sincerely,

Code A

Lesley Humphrey
Quality Manager

Silent copy to: Mrs. S. Hutchings
Mr. W. Hooper

Portsmouth HealthCare NHS Trust
26 AUG 1998
General Manager, Fareham/Gos