United Kingdom Central Council
for Nursing, Midwifery and Health Visiting

Private and confidential
Dr Eileen Thomas
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17 July 2001
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Dear Dr Thomas

Gosport War Memorial Hospital

Thank you for your letter of 21 June 2001 concerning the police investigation into the death of Mrs Gladys Richards at the above hospital. Mrs McAnulty has passed this matter to me for action.

The UKCC has received documentation from Hampshire Constabulary relating to this matter, indicating the concerns of the patient's family about the care Mrs Richards received. The names of three nurses have been raised by the police, these are Philip Beed, Ward Manager at Gosport War Memorial Hospital, Margaret Couchman, Staff Nurse at Gosport War Memorial Hospital and Christine Joice, whom I have been unable to identify from the papers supplied.

It is helpful to note your findings. In order that we may look into the case fully it would be helpful to have copies of any document or statement arising out of your investigation that you are able to provide.

Your assistance in this matter will be greatly appreciated and I look forward to hearing from you.

Yours sincerely

Police investigation
CHI
GMC

Code A

Stella Galea (Ms)
Case Manager, Professional Conduct

INVESTOR IN PEOPLE

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Mrs Liz McAnulty
Director of Professional Conduct
UKCC
23 Portland Place
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Our ref: ET/DB
Your ref:
Date: 21 June, 2001
Ext: 4353

Dear Mrs McAnulty

Gosport War Memorial Hospital

Ray Greenwood passed on to me your letter regarding a Police investigation which has taken place at Gosport War Memorial Hospital. I hope the following information is helpful.

The investigation is centred around a 91 year old woman who was admitted to Gosport War Memorial Hospital from Haslar Hospital. She had fallen in a nursing home sustaining a fractured neck of femur which was repaired with a hemi-arthroplasty. She was transferred to Gosport for trial of slow rehabilitation, where unfortunately she slipped from a chair and dislocated her hip prosthesis. She was transferred back to Haslar for manipulation under intravenous sedation. She was initially unresponsive following the sedation, but gradually improved and was transferred back to Gosport.

On arrival back at Gosport War Memorial Hospital, by ambulance, she was screaming in pain. A large haematoma had developed at the surgery site. She had multiple pathologies, and a decision was made that she was not fit for transfer back to Haslar again for further treatment. A palliative care approach was adopted and she was basically receiving end of life care.

There was family conflict before she died and this increased considerably in the period after her death, primarily regarding property.

The family raised a formal complaint with the Trust, after the second transfer from Haslar, and this was progressed through the local resolution procedures. However, the family withdrew before local resolution was completed. A full Trust investigation was carried out, which identified weakness in our systems relating to pain assessment and in relation to protocols for prescribing.

The family then complained to the Police along the grounds that Mrs R was unlawfully killed. The initial Police investigation could find no evidence for this. The family subsequently complained about the Police investigation process.

Anomalies were found in this first Police investigation, consequently, a much more thorough investigation of hospital processes was undertaken which led to the newspaper article.

Part of the complaint to the Police centres around a prescription for diamorphine written up by the clinical assistant for elderly medicine, a local General Practitioner. The ward concerned provides NHS continuing care and slow rehabilitation

In an attempt to ensure that her patient's pain was adequately controlled, the clinical assistant had written up diamorphine "40-200 mgs in 24 hours". This was to permit the nurses to increase the medication as required - because Gosport being a community hospital, doctors are not on site 24 hours per day. The nurses at Gosport responded responsibly to this and no dose above the lowest "40 mgs" was every administered before Mrs R died.

Our response to this complaint/prescribing practice has been rigorous, with training of all staff undertaken, together with the implementation of pain charts, clear protocols and a detailed Trust policy for all staff.

The practice of wide prescribing is no longer undertaken and the GP concerned is no longer employed by the Trust. I am confident that the nursing staff acted appropriately and responsibly at the time, and that valuable lessons have been learnt and changes implemented. I will be very happy to provide you with any further details you require.

Yours sincerely

Dr Eileen Thomas
Nursing Director

Copies to: Dr Ian Reid
Mrs Barbara Melrose
Mrs Fiona Cameron
Mr Ray Greenwood