HAMPSHIRE Constabulary

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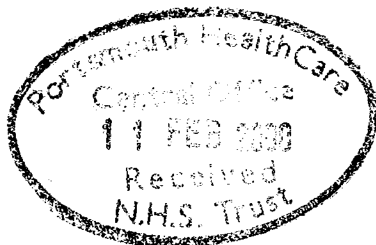

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Our Ref. HQ/E/CID/DCI/2000

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8th February 2000

Mrs L. HUMPHREY
Quality Manager
Portsmouth Health Care NHS Trust
Central Office, St James' Hospital,
Locksway Road, PORTSMOUTH,
Hampshire. PO4 8LD

Dear Lesley,

I hope you received the x-ray images and papers that I left for you at the Reception Desk at St James' Hospital on the 29th January 2000. A young lady called Code A kindly signed for them. Did you understand my scribbled notes about the small alteration to page 6 of your statement? I would be grateful if you would make the alteration, initial it, and send it back to me. I apologise for putting you to this trouble, I should have spotted it first time around.

I wonder if I could now, as touched upon in my letter of the 29th January 2000, raise a few issues associated with obtaining additional information and seek your help/advice as regards how I can best deal with them.

Some of the matters may, already, have been referred to but it would be helpful if I could review and consider them again.

Perhaps it would be beneficial if, once you have had an opportunity to consider the points, we met and discussed these matters.

1. Mrs RICHARDS was conveyed from the Royal Hospital Haslar to the Gosport War Memorial Hospital on Monday 17th August 1998. It has been reported that she was transported by a 'Mainline' Ambulance Crew. It was further reported that 'Haslar' arranged this transport and telephoned 'Daedalus' to inform them that a canvas (with two poles inserted) could not be found to put Mrs RICHARDS on. Instead, it was reported, two sheets were used to lift the patient who began crying and screaming in the ambulance and continued for some time after her arrival at the Gosport War Memorial Hospital. Having regard to this patient's condition,

and the fact that the method of carriage may have aggravated her condition, can you please advise me.

(a) Were any reports regarding this incident prepared by any employee of the Portsmouth Health Care (NHS) Trust?

I am, of course, aware of the Report which was prepared by S.M. HUTCHINGS after Code A Code A letter of complaint and prior to Mr MILLETT's letter in reply which was dated the 22nd September 1998.

(b) Were the circumstances formally drawn to the attention of the Royal Hospital Haslar?

(c) What is a 'Mainline' Ambulance and who is responsible for this service and the staff?

(d) Does the Portsmouth Health Care (NHS) Trust have rules or guidelines which deal with the carriage and transportation of a patient in Mrs RICHARDS condition?

(e) Would it have been appropriate to carry a patient in Mrs RICHARDS' condition in the manner which was apparently employed?

(f) Are you aware of any disciplinary action following this incident?

Presumably, if any such disciplinary action had been taken, evidence would have been required from staff at the Gosport War Memorial Hospital.

2. You have advised me that medical care is provided for patients at the Gosport War Memorial Hospital on a 'visiting' or 'on call' basis.

(a) Whilst Mrs RICHARDS was admitted to the Gosport War Memorial Hospital were there any medical staff, apart from Dr BARTON, with responsibility for her care?

(b) Could you please provide me with details of the 'on call' Rota in force during the time that Mrs RICHARDS was admitted to the Gosport War Memorial Hospital?

(c) Having regard to the content of Dr LORD's Report, can you please tell me who was providing Consultant cover, for the Gosport War Memorial Hospital, during the period that Mrs RICHARDS was admitted?

(d) **Can you please provide me with details of the contractual arrangements which govern the employment of medical staff at the Gosport War Memorial Hospital?**

(e) **Could you tell me if there is was a policy in place, during the time that Mrs RICHARDS was admitted to the Gosport War Memorial Hospital, which dealt with the circumstances in which a patient could be referred to the Royal Hospital Haslar after 'office hours'?**

3. A Syringe Driver was used in Mrs RICHARDS case.

(a) **Can you tell me how often Syringe Drivers are used at the Gosport War Memorial Hospital?**

(b) **Can you comment on the level of skill of the Nursing Staff, responsible for Mrs RICHARDS care whilst she was admitted to the Gosport War Memorial Hospital, in monitoring Syringe Drivers in the absence of the Clinical Assistant?**

(c) **What was the nature and dose of the drug administered in the Syringe Driver?**

(d) **Who checked the dose of the drug being administered by the Syringe Driver?**

4. In terms of other complaints about the clinical management of patients at the Gosport War Memorial Hospital by Clinical Assistants.

(a) **Have any such complaints been made?**

and, if so,

(b) **What was the nature of these complaints?**

(c) **Have any other complaints been made about the terminal care of elderly people, generally, at the Gosport War Memorial Hospital?**

and, if so,

(d) **What was the nature of these complaints?**

HAMPSHIRE Constabulary

I appreciate that this will cause you some extra work and I fear that I may, as time goes on, require yet more information.

I appreciate your support.

Yours sincerely,

Ray Burt
Detective Chief Inspector

Never formally
replied to — as
situation changed
year.

Peptac
Liquid

Information requested re. Mrs G Richards

(Numbers correspond to those in the request)

1.

a) No. The over riding priority following Mrs Richards transfer, was arranging an Xray and controlling her pain.

b) No. See a)

c) Mainline is the transport service contracted to the Trust, for non emergency transportation of patients.

d) I believe the Trust has patient transportation guidelines as part of the contract, but I do not hold a copy of them at ward level.

e) My professional view is that a canvas & poles or Canvas and a Patslide would be appropriate for the transfer of an immobile patient with a hip injury. However if a patient had arrived on the ward without a canvas under them, it would be necessary to assess whether or not more discomfort and distress would be caused by putting a canvas in place.

f) No see a) (Haslar)

2.

a) Dr Lord was consultant to Mrs Richards. Outside of normal working hours, and when Dr Barton was on leave, the ward is covered by the duty partner from Dr Bartons practice. I know that she was seen by Dr Peters on the day she was transferred back to GWMH. To see whether she was seen by other partners it would be necessary to consult the nursing & medical records (specifically the contact record in the nursing notes), which I do not currently have to hand. ?if nec duty consultant at eld med QAH
b) This should be available from the Forton Road practice.
c) At the time of Mrs Richards admission, where consultant advice was needed, normal practice would be to contact the duty consultant for elderly services.
d) ? Pam Keeping
e) The policy for referring and transferring patients both in and out of working hours, is based on the judgement of nursing and medical staff, following assessment of the presenting problem or condition, together with the patients overall condition. Where appropriate the decision whether or not refer the patient is also discussed with the patient and/or family.

The rational for this, is that hospital transfer is traumatic and stressful, and can in itself be detrimental to the well being and condition of a patient, and be distressing for the family. It is a practice which is well understood, and works well.

3.

a) Syringe drivers are used frequently throughout the hospital. The exact usage would be difficult to say, as usage fluctuates. On Daedalus we would typically use syringe drivers at least twice a month.
b) All qualified nursing staff on Daedalus Ward are highly experienced in the use of syringe drivers, the majority have been on syringe driver study days, and all are competent in this area of practice.

Because nursing staff are caring directly for patients, they are able to accurately assess and monitor the effectiveness of the syringe driver, and use their observations of the patient to ensure drug administration via the driver is appropriate to the patients needs.

c) & d) The syringe driver was initially set up by myself (C.N. Beed) and subsequently would have been changed by whichever nurse was on duty, this would be on the drug record which I do not have to hand. A second nurse would have checked each change of dosage, as required for controlled drugs.

4.

a) Not to my knowledge

Terminal Care
Code A who complained / disappeared
left us with body. Refused contact

Never sent!

DRAFT

LH/YJM

4378

Dear Ray,

I am finally able to answer the questions posed in your letter to me dated 8th February, 2000. The delay has been caused by annual leave and other work pressures, not because the information was difficult to find. We have some concerns, however, that the line of enquiry now seems much broader; we will not be able to answer all your questions as some of the issues were not under our control. The information provided here should not be considered as from "an expert" witness, these are merely collective responses to your questions.

It is probably simplest if I respond in number format, as the questions were posed:

1. Transport from Haslar Hospital to Gosport War Memorial Hospital

   Haslar Hospital, not Portsmouth HealthCare Trust, were responsible for making the arrangements for Mrs. Richards' transfer and thus were responsible for ensuring the suitability of the transport.

   (a) No, other than the report prepared by Mrs. Hutchings.

   (b) No. Haslar were aware of the circumstances, i.e. that they did not provide a canvas for lifting by the Mainline crew. The over-riding concern when Mrs. Richards arrived at Gosport was to deal with her immediate needs, i.e. X-ray and pain relief.

   (c) Mainline is a local transport service who contract with local health services to provide non-urgent (i.e. non-emergency) transport. The service provides for all mobility types; walking, wheelchair and stretcher patients. (Mainline was renamed as Portsmouth and Hampshire Patient Transport Services Limited (PHPTS) on 1st April, 1997 but the term "Mainline" has stuck in general usage.)

I am not sure if Haslar have their own contract with Mainline or if they access this service via the contract held by the Health Authority. The service and staff are currently managed by PHPTS who are responsible for providing the service within the contracted agreement with the stated health care agency.

(d) There are guidelines within the contract with Mainline. In this case, however, the transport was booked by Haslar and it was their responsibility to ensure it was suitable transport.

(c) As the transport arrangements were made by Haslar, yet the complaint and police investigation focus on Portsmouth HealthCare Trust, it seems a little awkward for this question to be posed to us. We can say that a Mainline ambulance would usually be deemed appropriate for this type of stretcher case. The appropriate method of moving the patient from bed to ambulance stretcher would be a canvas and poles, or a canvas and Patslide.

(f) We are not aware of any such action; you would need to pose this question to Haslar.

2. <u>Medical Cover at Gosport War Memorial Hospital</u>

(a) Dr. Lord had overall responsibility for care, but because of the dates of the two brief periods of admission she did not see Mrs. Richards, nor was she specifically consulted about her care. Dr. Lord visits Gosport War Memorial Hospital every Monday afternoon. Mrs. Richards was admitted to Daedalus Ward on Tuesday, 11th August, 1998 and transferred to Haslar Hospital on Friday, 14th August, 1998. She was readmitted on the afternoon of Monday, 17th August, 1998 and died on the afternoon of Friday, 17th August, 1998. On 17th and 18th August, 1998 Dr. Lord was away on study leave.

In providing "on call" cover for Dr. Barton, two of her general practitioner colleagues were involved in Mrs. Richards' care: Dr. Briggs on the afternoon of 13th August, 1998 and Dr. Peters on the evening of 17th August, 1998 (see the nursing contact records for these dates).

(b) There is no "on call" rota in the sense that there would be in an acute hospital. Out of hours medical cover is provided by Dr. Barton and her general practitioner practice colleagues (as part of the clinical assistant contract). The nursing staff would telephone the general practitioner on call for the practice that night/ weekend, etc..

/continued - page 4

The prescription sheet within Mrs. Richards' medical records (copy already supplied) and the ward controlled drug register confirm these details. (I can supply a copy of the register if you wish; the original must remain on the ward.)

(d) The syringe driver was charged on four occasions, as explained above. There are very strict procedures about the administration of controlled drugs, such as Diamorphine, whereby they must be checked by two qualified nurses. The nurses responsible for setting up the syringe drivers were as follows:

Date	Time	Given by	Checked by
18.8.1998	11.45 a.m.	C/N Beed	S/N Couchman
19.8.1998	11.20 a.m.	C/N Beed	S/N Brewer
20.8.1998	10.45 a.m.	S/N Couchman	S/R Lock
21.8.1998	11.55 a.m.	S/N Joice	S/N Brewer

Sister Lock was called from another ward to check the setting up of the syringe driver. Following setting up of a syringe driver, the working of the driver, the injection site, and the patient's condition would be closely monitored, as part of routine nursing care.

4. <u>Other Complaints about Clinical Management by Clinical Assistants</u>

(a) Having checked the complaint file for the past two years, there is only one other complaint which specifically refers to the action of a Clinical Assistant.

(b) This complaint was about manner and attitude.

(c) In the past two years there have been four complaints subsequent to death. Whether you could class these as complaints about "terminal care" might be questionable.

(d) Issues included: communication/general care/attitudes/medication. One of these which challenged the use of opiate analgesia, has been through the NHS complaints procedure and had external opinion support the medical treatment given.

I hope this information helps. I would be happy to meet you to talk this through.

Yours sincerely,

Dr. Knapman (senior partner at the practice) may be able to advise you which general practitioners were on call on which days if this would help your investigation. We can probably assume, but you may wish to check, that Drs. Briggs and Peters were on call on the dates stated above.

(c) Dr. Lord would provide consultant cover for her patients during the normal working days when she was not on study leave - i.e. 11th to 14th August, 1998, and 19th to 21st August, 1998. Cover for the 17th and 18th August, 1998 (when she was on study leave), and out of hours would be provided by the "on call" consultant for elderly medicine on the days in question. The attached rota copy shows that Dr. Grunstein was on call for the two week period in question.

(d) See the attached contract documents for details of the contractual arrangements for the employment of clinical assistants at Gosport War Memorial Hospital.

(e) There was no written policy governing the transfer of patients to accident and emergency at Haslar "out of hours" at the time of Mrs. Richards' admission. The decision would be made by the duty doctor on the basis of assessed medical need, taking all relevant circumstances into consideration. Patients can and could be referred and transferred at any time of the day or night.

3. Use of Syringe Drivers

(a) Syringe drivers are used frequently throughout the hospital. The exact usage would be difficult to specify as this fluctuates. On Daedalus Ward they would typically use syringe drivers for at least two patients per month.

(b) All qualified nursing staff on Daedalus Ward are experienced in the use of syringe drivers; the majority have been on syringe driver study days and the clinical manager deems them all competent in this area of practice. The nursing staff are responsible for the administration of all medications, including monitoring of syringe drivers in accordance with the prescription written by the doctor.

(c) Two drugs were administered via the syringe driver, as detailed in the prescription sheet within the medical records.

- Diamorphine (an opiate analgesia) was given at the rate of 40 mgs in 24 hours; commenced on 18th August, 1998 with the syringe being recharged 24 hours later on 19th, 20th and 21st August, 1998.
- Haloperidol (an anti-psychotic drug) was given at the rate of 5 mgs in 24 hours; as detailed above.