Private and confidential
Gillian Mackenzie

Code A

24 August 2010
12053/MACKENZIE/Code A
Direct line: Code A
Direct fax: 020 7242 9579
Fitness.to.practise@nmc-uk.org

Dear Mrs Mackenzie

Registered nurses at Gosport War Memorial Hospital

I write with reference to your letters to Ian Todd dated 25 and 29 March 2010. As I have since explained to you, Mr Todd has left the Nursing and Midwifery Council and the letters were subsequently passed to me.

I would like to begin by apologising for the long delay in replying to you. It had been my intention to respond earlier but pressure of work and changes in this office have prevented me from doing so. I offer this as an explanation rather than as an excuse and am mindful that you deserved a response earlier.

Preliminary Proceedings Committee, 18 September 2001

I have now retrieved a copy of the papers that were considered by the Preliminary Proceedings Committee (PPC) on 18 September 2001 in relation to the care provided to your mother, Gladys Richards.

The committee received the following information

- A report drafted by the NMC's staff, summarising the referral;
- Documents provided by Portsmouth Healthcare Trust;
- Documents provided by the police;
- A copy of Mrs Richards' notes;

The committee was advised that the referral for consideration was from Hampshire Constabulary. It was advised that three nurses had been interviewed by the police:

Code A

The committee was informed the following about Mrs Richards: that she had been a resident at Glen Heathers Home since 1994 until 29 July 1998 when she was admitted to Haslar Hospital following a fall. She had suffered a fractured neck of femur and made a good recovery from a surgical repair. She had been admitted to Gosport War Memorial Hospital on 11 August 1998 to give her the opportunity for mobilisation. Following a fall that resulted in the dislocation of her hip she was returned to Haslar Hospital on 14 August 1998. She went back to Gosport War Memorial Hospital on 17 August 1998. A haematoma developed at the site of the manipulation and she died in hospital on 21 August 1998.

The committee was advised that the police investigation was started because of concerns raised by Mrs Richards' family. It was advised that the main concern was about the medical treatment Mrs Richards had received with the implication that that she was given high doses of morphine instead of proper treatment and nourishment and that consequently she died when she could have survived. It was advised that while Mrs Richards' family had previously complained to the Portsmouth Healthcare NHS Trust raising wider concerns about her treatment, it had never made specific complaints about specific nursing staff.

The committee was informed that Mrs Richards' family's concerns were outlined in the police statement of Mrs Lack and also in the correspondence with Portsmouth Healthcare NHS Trust. A summary of the family's concerns was provided to the committee as follows:

1. On 12 August 1998, when first admitted to Gosport War Memorial Hospital, Mrs Richards' agitation was put down to dementia when in fact it could have simply that she wanted the toilet. She could have treated with a milder form of pain relief;

2. When she suffered her fall, a doctor could have been called before she was moved to her chair;

3. On 13 August it took a long time for staff to identify that she had suffered a fall. Her distress was continually put down to her dementia and she was not admitted to Haslar Hospital's Accident and Emergency department until 24 hours after the fall;

4. On 17 August when she was returned to Haslar Hospital she was obviously in extreme pain from being positioned wrongly. Why was nothing done about this until Mrs Lack arrived and assisted the nurse to move her?

5. When Mrs Richards developed a haematoma, why was a decision made to do nothing other than to keep her pain free?

The committee was advised of the outcome of the Trust's investigation at the time. It was informed that the decisions about the quantity of pain relief and the decision not to treat Mrs Richards after she developed the haematoma were medical ones and that it had found that at no time had the nursing staff administered anything but the prescribed minimum of morphine.

The committee was advised that from a review of the existing documentation the following possible allegations could be put to registrants following the concerns expressed by Mrs Richards' family:

- Cooperated with inappropriate management of Mrs Richards' care by Dr Barton;
- Inadequate care plan/nursing notes;
- Failure to tell Mrs Richards' family that she had been inappropriately transferred;
- Failure to attend to Mrs Richards when was in pain on 17 August 1998;
- Failure to take action when Mrs Richards appeared to be drowsy on 12 August 1998 and misinterpreted her anxiety as due to dementia.

It should be stressed that these were possible allegations suggested to the committee, but ultimately the decision was that of the committee.

The committee were invited to take the following into account in making its decision:

- The police were not proceeding with any criminal prosecution of any registrant;
- The Trust's findings do not support any allegations of misconduct;
- Mrs Richards' family's complaints were mainly about the medical treatment received by her and although they have identified some mistakes and delays in the system their evidence does not provide proof to the required standard (which, at that time, was beyond reasonable doubt) of professional misconduct by any registrant;

The committee declined to proceed with the case. It had the opportunity to pursue issues relating to the referral but it decided not to. As it was not the practice for the Preliminary Proceedings Committee to give reasons for its decisions at that time, it did not do so.

Referring back to our earlier letter of 24 March 2010, the NMC did not write to you at the time as you were not the complainant in this case nor had you made any complaint directly to the NMC.

To confirm, the information the committee considered is as follows:

- Copy correspondence from Hampshire Constabulary to Liz McAnulty, Director of Professional Conduct, 18 May 2001. In this letter, reference is made to Professor Livesley's report where he names registered nurses "and has expressed his view that there may be a measure of criminal culpability";
- Police statement of Lesley Frances Lack, 31 January 2000;
- Police statement of Gillian Mackenzie, 6 March 2000;
- Copy correspondence from Portsmouth HealthCare NHS Trust to NMC, 21 June 2001;
- Copy correspondence from Portsmouth HealthCare NHS Trust to NMC, 27 July 2001, including copies of the following:
    - Copy of a letter from Lesley Lack to the Trust (undated);
    - The Trust's investigation report, September 1998
    - A copy of correspondence between the Trust and Mrs Lack, 22 September 1998
    - Copy correspondence between the Trust and the police, 19 January 1999, and supporting documents
    - Copies of the practice guidelines and policies since introduced;
- A copy of Mrs Richards's medical records (approximately 147 pages).

Later referral of registered nurses at Gosport War Memorial Hospital

I would like to return to the issue of why we wrote to you on 27 September 2002.

Five members of the public made complaints to the NMC about the care their relatives had received at Gosport War Memorial Hospital. While I appreciate that you are in contact with various families, I am not in a position to disclose the complainants' names to you as their correspondence to the NMC remains confidential.

The PPC considered this later referral in September 2002 and the committee decided to adjourn consideration of the case to await the outcome of investigations by the Crown Prosecution Service. This was ultimately reconsidered by the PPC in April 2010.

Our records show that you telephoned our office in April 2002 and were asked to submit your concerns in writing. No written response was received.

A further handwritten note was made on 3 August 2002 and you and your sister's addresses were taken down together with some information about the possibility of the police case being reopened. You and your sister are designated "Further complainants" in this note.

I believe that this may be where the error lay and the case officer at the time in September 2002 wrote to you and your sister believing you to be complainants in the later referral. In summary, it was an administrative error which we tried to correct and explain before the case was referred back to the Preliminary Proceedings Committee in April 2010. I would like to once again apologise for this misunderstanding.

The Preliminary Proceedings Committee has considered the issues of care given to Mrs Richards and has decided not to take any further action. The committee at the time had access to her medical records, contemporaneous notes of the Trust's investigation and details of your concerns in the form of the police statements and copy correspondence between the Trust and your sister. It had available to it a range of choices if it had been minded to pursue the referral in September 2001.

We do not feel that there is information available to justify setting that decision aside, based on the issues and material the committee considered. It is open to you to seek independent legal advice about obtaining a judicial review of the PPC's decision.

I am not in a position to comment on the police investigation, the GMC's proceedings or that of any other organisation. The purpose of this letter is to advise you of how the referral concerning the care of Mrs Richards was considered, to confirm details of the information considered and to attempt to clarify why we wrote to you in September 2002.

In closing, I would like to once again apologise for the delay in writing to you and for any feelings of distress or frustration this has caused you. This is a matter of regret for me as I know that you will be disappointed by our decision and it has never been my intention to add to your distress.

Any future correspondence regarding this matter should be addressed to Jackie Smith, Director of Fitness to Practise.

Yours sincerely

Code A