Operation Rochester

Advice.

1. Introduction

1.1. On 21 August 1998 Gladys Mabel Richards, aged 91 died.

1.2. At the time of her death Mrs Richards was a patient at the War Memorial Hospital Gosport Hampshire.

1.3. Following her death, Mr Richards' daughter, Lesley Lack and Gillian Mackenzie complained about the standard of care Their mother received at the War Memorial Hospital in the days leading to her death.

1.4. A thorough investigation into the events leading to and surrounding Mrs Richards's death has been carried out by the Hampshire Constabulary.

1.5. I have been asked to advise on the question of whether the evidence reveals the commission of any criminal offence by any doctor or member of the nursing staff who cared for Mrs Richards during the period of her admission to the hospital, and, if so, whether there is a realistic prospect of conviction

1.6. I should say at the outset that after careful consideration of all the materials provided to me I have reached the conclusion that the evidence does not reveal the commission of any criminal offence.

2.1.7. In reaching my conclusion I have, of course, had regard to the Code for Crown Prosecutors.

2. Background.

2.1. Gladys Mabel Richards was born on 13 April 1907.

2.2. In about 1991 Mrs Richards was admitted to a residential nursing home in the Basingstoke area. In 1994 she moved to the Glen Heathen Nursing and Residential Home in Lee on Solent in Hampshire.

2.3. By early 1998 Mrs Richards' condition began to deteriorate. It appears that she became increasingly forgetful and she was less able physically. By late July 1998 she had suffered a number of falls

2.4. On 29 July 1998, Mrs Richards fractured the neck of her right femur and was transferred from the Glen Heatten Nursing Home to the Royal Hospital Haslar, Gosport where she arrived at about 9.00pm.

2.5. On 30 July 1998, despite her confused state, the medical staff at the Royal Hospital Haslar considered her suitable for implantation of an artificial hip joint.

2.6. Mrs Richards remained at the Haslar hospital for a further eleven days and appeared to be making a good recovery.

2.7. On 11 August 1998, having been seen by a consultant geriatrician, Mrs Richards was transferred for rehabilitation to the War Memorial Hospital Gosport where she was admitted to the Daedalus Ward.

2.8. Later that day, Mrs Richards was seen by Doctor Jane Barton, the clinical assistant in elderly medecine. Doctor Barton made an entry in the medical case records which was to the following effect

"Impression frail demented lady
not obviously in pain
Please make comfortable
... I am happy for nursing staff to confirm death"

2.9. Doctor Barton prescribed a number of drugs

(i) oramorph (an oral morphine preparation) to be administered by mouth at four hourly intervals;
(ii) diamorphine (a powerful opioid analgesic);
(iii) hyoscine (a drug used to reduce secretions);
(iv) midazolam (a sedative).

2.10. On 13 August 1998, Mrs Richards' artificial hip joint became dislocated.

2.11. On 14 August 1998 Doctor Burton arranged for Mrs Richards to be transferred back to the Hastar Hospital when the dislocation of the hip was reduced.

Following the operation
2.12. Mrs Richards did not regain consciousness until 1.00am on 15 August 1998.

2.13. On 17 August 1998, Mrs Richards was returned to the War Memorial Hospital. Her discharge notes from the Hastar hospital refer to the need for 'care for the next four weeks to ensure her progress'.

2.14. It seems that when Mrs Richards was discharged from the Hastar hospital there was not a stretcher available and she was carried to and from the

ambulance on a sheet.

2.15. By the time Mrs Richards was seen at the War Memorial Hospital she was very distressed and obviously in pain.

2.16. That afternoon she was x-rayed. This was done to ensure that she had not suffered another dislocation of her hip. Although no dislocation was found it appears that Mrs Richards was clearly in pain.

2.17. On the morning of 18 August 1998 it was discovered that Mrs Richards had developed a massive haematoma around the site of her hip joint.

2.18. Doctor Burton ~~decided to~~ prescribed diamorphine, Midazolan, haloperidol and hyoscine to be given continuously subcutaneously by way of a syringe driver over periods of twenty-four hours

2.19. This subcutaneous administration of drugs continued until Mrs Richards' died on 21 August 1998.

2.20. Doctor Burton gave the cause of death as bronchopneumonia.

2.21. Mrs Richards was cremated.

2.22. Daedalus Ward at Gosport War Memorial Hospital has twenty-four beds. The consultant in charge of the ward was doctor Lord. She conducts a ward round twice a week and was contactable at other times on the telephone.

2.23. Doctor Burton was the clinical assistant who visited the ward each weekday morning

2.24. Philip Reed was the Clinical manager in charge of the ward.

2.25. On duty at any given time would be five trained staff and eleven health care support workers.

2.26. A pharmacist, Jean Dalton, would visit once a week and, if necessary, give advice on medication.

3. Mrs Lesley Lack.

3.1. Mrs Lack, the daughter of Mrs Richards, is a retired Registered General Nurse. In a statement dated 31 January 2000 she ~~makes a number of~~ provides a narrative of the relevant events and makes a number of observations.

3.2. The statement may be summarised as follows:

(i) Mrs Lack was unhappy with the care her Mother had been receiving at the nursing home and had made a decision that her mother would not return there.

(ii) Following the operation on 30 July 1998 she observed that her Mother was responding to physiotherapy and that her medication had been reduced. Also, significantly, she was no longer in need of pain relief.

(iii) On 12 August 1998 she was surprised to discover that her mother had been prescribed 'oramorph' for pain relief. She was told that her Mother had been displaying anxiety and crying out. Mrs Lack notes that the cause of the anxiety had not been investigated

(iv) On 13 August 1998 she was informed that her mother had fallen from a chair.

(v) Between 15 August and 17 August 1998, following the operation to manipulate the hip back into place Mrs Lach noticed that her mother appeared to be recovering

(vi) On her return to the War Memorial Hospital on 17 August 1998 Mrs Lach saw her mother lying in a position which caused her great pain. She notes that, again, the source of the pain was not investigated

(vii) On 18 August 1998, when the workings of the syringe driver were explained to her she told the ward manager, Philip Reed, "just let her be pain free". She did not agree to her mother being simply subjected to a course of pain relief treatment "which I knew would effectively prevent steps being taken to facilitate her recovery and would result in her death."

3.3. It is a feature of Mrs Lachi's evidence that she wishes to draw a distinction between the (apparently high) standard of care received at the Hasler Hospital and the care received at the War Memorial Hospital. As she says, "the hope I wish to

highlight is that when my mother's condition was correctly diagnosed and treated the pain and discomfort were removed and she recovered well.

3.4. It is right to observe that Mrs Lachi's statement is based upon notes she kept following her mother's transfer to the War Memorial Hospital on 11 August 1998. These notes were prepared because she had been advised by Lesley Humphrey, the Quality Manager for the Portsmouth Health Care Trust, to whom she had voiced her concerns that complaints should be investigated.

4. The Evidence of Mrs Gillian Mackenzie

4.1. Mrs Gillian Mackenzie is the ~~sister~~ elder daughter of Mrs Richards and the sister of Lesley Lack. Mrs Mackenzie's statement is in similar terms to that provided by her sister.

4.2. The matters of significance appear to be as follows:

(i) On 17 August 1998 it was obvious that Mrs Richards was in great pain.

(ii) From 17 August 1998 she and her sister were given a great deal of attention by the ~~nursing~~ ward Manager Philip Reed

who acknowledged that Mrs Richards was in great pain and that something had to be done.

(iii) Doctor Barton was told that the Hasler Hospital would accept Mrs Richards but her response was that she did not think it right to send her back to the Hasler Hospital;

(iv) On Tuesday 18 August 1998 Philip Reed explained that nothing could be done for Mrs Richards, who had developed a massive haematoma at the site of her hip operation and the only possible means of treating her was to put her on a syringe driver with Diamorphine so that she would have a pain free death

(v) Both Mrs Lach and Mrs Mackenzie agreed to the course proposed

(vi) Doctor Barton spoke to the sister to ask if the use of the syringe driver had been explained to them and went on to mention the possibility of a chest infection developing

5. Professor Livesley.

5.1. Professor Brian Livesley, the University of London; Professor in the Care of the Elderly has provided a report into the circumstances surrounding Mrs Richards' death.

5.2. In his summary of the relevant facts Professor Livesey draws attention to the following matters:

(i) On 11 August 1998 Doctor Barton prescribed oramorph and large dose-ranges of diamorphine, hyoscine, and midazolam. These were to be given subcutaneously and continuously over periods of twenty-four hours for an undetermined number of days.

(ii) On 17 August 1998 there is no evidence that Mrs Richards, although in pain, had any specific life-threatening and terminal illness that was not amenable to treatment and from which she could not be expected to recover. Despite this on 18 August 1998, Doctor Barton, who did not seek any other medical opinion, prescribed diamorphine, midazolam, haloperidal and hyoscine to be given subcutaneously and continuously over periods of thirty four hours.

(iii) Neither midazolam nor haloperidol is licensed for subcutaneous administration.

(iv) When the syringe driver was being used to administer the subcutaneous drugs, there is no evidence that Mrs Richards was given fluids or food in any appropriate manner

(v) There is no evidence that in fulfilling her duty of care Doctor Barton reviewed appropriately Mrs Richards's condition from 18 August 1998 to determine if any reduction in the drug treatment being given was indicated.

(vi) There is no evidence that in fulfilling their duty of care Mr Phillip Reed Ms Margaret Couchman and Ms Christine Joice reviewed appropriately Mrs Richards condition to determine if any reduction in the drug treatment they were administering ~~were~~ was indicated.

(vii) There is, however, indisputable evidence that the subcutaneous administration of drugs by Syringe driver continued without modification from 18 August 1998 until Mrs Richards died on 21 August 1998

(viii) Although doctor Barton recorded that death was due to bronchopneumonia there is no clinical or pathological evidence that this was correct.

(ix) It is beyond reasonable doubt that the death of Mrs Richards was the result of continuous subcutaneous administration of dianorphine, haloperidal, Midazolan and hyoscine in the dosages given.

5.3. In Professor Livesley's opinion Mrs Richards was unlawfully killed, by the continuous administration of drugs actively prescribed by doctor Barton. He further concludes that Philip Reed, Margaret Cochrane and Christine Joice knowingly and continuously administered dianorphine, haloperidal, Midazolan and hyoscin to Mrs Richards when they should have recognised the fatal consequences of so doing.

6. Doctor Barton.

6.1. Doctor Barton is aged 52 (date of birth 19 October 1948). She qualified in 1972 at Oxford University with degrees MA, BM, BCh. In 1988 she took up the post of clinical assistant in elderly medecine at the War Memorial Hospital on a part time basis.

6.2. On 25 July 2000 Doctor Barton was interviewed under caution at Fareham Police Station. She declined to answer questions but produced a lengthy prepared statement which contained the following points:

(i) upon admission on 11 August, Doctor Barton was of the opinion that, because of her dementia, her hip fracture and her recent major surgery, Mrs Richards was close to death. She scored 2 on the 'Barthel' scale a measurement of general physical and life skill capability. The maximum available score is 20;

(ii) she wrote a prescription for a number of drugs which would allow the nursing staff to respond to Mrs Richards' needs based on their own clinical assessment;

(iii) the oramorph given, was an an appropriate level of pain relief after such a major orthopaedic procedure;

(iv) when she was transferred back to the War Memorial Hospital on 17 August 1998 Mrs Richards had been on intravenous morphine until shortly before her transfer. This was not known to Doctor Barton at the time but in her opinion it explains Mrs Richards's apparent peacefulness upon transfer;

(v) she was preparing to see Mrs Richards's daughters to explain to them what she believed to be Mrs Richards's inevitable decline;

(vi) by 18 August 1998 there had been a marked deterioration from when she had first seen the patient on 11 August; her condition confirmed Doctor Barton's view that she was dying: she was "barely responsive and was in a lot of pain";

(vii) she confirms that she spoke to the daughter who reluctantly agreed to the diamorphine administered by syringe driver; she states that 'this drug, the dose used and this mode of administration are standard procedures for patients who are in great pain but who cannot safely take medecines by mouth";

(viii) to administer fluids would have been inappropriate on the grounds that it would have caused Mrs Richards further pain and distress;

(IX) she considered that a further transfer of such a frail unwell elderly lady was not in her best interests and would have been inappropriate;

(X) on the morning of 19 August 1998, she considered that Mrs Richards had a "rattly" chest and had developed bronchopneumonia; that is why she prescribed hyoscine;

(XI) there was no significant change in Mrs Richards' condition when she saw her on 20 August 1998;

(XII) following Mrs Richards's death she discussed the case with the Coroner's Officer, a police officer at Cosham Police Station. The death certificate was signed giving the cause of death as bronchopneumonia. The Coroner's Officer was satisfied that no further investigation was required.

68. In co