ADVICE

Introduction

1. This investigation arises from complaints made by the daughters of the deceased about the care their mother had received on Daedalus ward at the War Memorial Hospital, Gosport. In short, the daughters are extremely dissatisfied with the standard of care displayed by Dr Barton and the nursing staff.

2. The impetus for the complaints comes largely from Mrs Lesley Lack, one of the deceased's daughters, who was a nurse for 41 years before her retirement in 1996. Prior to her retirement, she had been involved in the care of elderly people for 25 years.

3. A report was prepared by Professor Livesley 'for the purpose of providing an independent view about whether or not there is evidence to support criminal proceedings against any party to the care of Mrs Gladys Richards'. The report lends support to the daughters' criticisms.

4. I will consider the report, the evidence of Mrs Richards' daughter Mrs Lack, and Dr Barton's statement in interview, before giving a brief legal analysis.

Professor Livesley's report

5. Prof. Livesley raises concerns about what appears to him to be a 'culture of inappropriate clinical practice' on Daedalus ward at War Memorial Hospital. The reasons for his concern are as follows:

Mrs Lack had serious reservations about the standard of care at Glen Heathen.

"When Mrs Richards was first admitted to Daedalus ward for rehabilitation I can find no evidence that she would require the subcutaneous drugs that Dr Barton prescribed. In this connection it is significant that, although prescribed, the nurses did not administer these drugs at that time. In addition, and on her readmission to Daedalus ward, there is no evidence that Mrs Richards had a condition requiring the continuous subcutaneous administration of diamorphine, midazolam, haloperidol and hyoscine and the lack of appropriate fluid and food intake until she died."

6. A summary of his report appears at page 1. He draws the following conclusions:

   (i) Dr Barton, a registered medical practitioner, prescribed the drugs **diamorphine, haloperidol, midazolam** and **hyoscine** for Mrs Gladys Richards in such a manner as to cause her death.

   (ii) Mr Beed, Ms Couchman and Ms Joice were also knowingly responsible for the administration of these drugs.

   (iii) As a result of being given these drugs, Mrs Richards was unlawfully killed. Since 1991 Mrs Richards had been resident in a nursing home, the first in Basingstoke area the second Glen Heathen in Lee on Solent.

7. A synopsis of events appears at pages 4-5. It provides a more detailed chronology and a commentary based on Prof. Livesley's opinions:

By early 1998 dementia was more marked and she was less able physically. She began to have falls.

   Wednesday (i) on 29th July 1998, Mrs Richards fractured the neck of her right femur and was transferred to the Royal Hospital Haslar, Gosport; fall approx 2.50pm arriving there about 9 pm.

   Thursday (ii) on 30th July, despite her confused state, the medical staff at Royal Hospital Haslar consider her suitable for implantation of an artificial hip joint;

She remained at Haslar for a further eleven days and appeared to be making a good recovery.

4th interview

(12) Upon readmission to GWMH on **17th August**, it was clear that her condition had improved. **(14)** When she was lifted from the ambulance onto a hospital bed, she was on a sheet rather than a canvas. GWMH had been telephoned and informed that no canvases had been available at Haslar. **(17)** Soon after her arrival, and once she had been clerked in by Dr BARTON, Mrs RICHARDS became very unsettled and obviously in pain. **(19)** Margaret COUCHMAN, along with Mrs LACK, repositioned Mrs RICHARD's leg to try and alleviate the pain. **(21)** BEED had discussions with Mrs LACK, who was concerned about the amount of pain her mother was in. He was working very much in conjunction with the family. One of the reasons why she was given so much Oramorph was that Mrs RICHARDS wanted her mother to have more analgesic drugs.

(24) It was simply an oversight that not all of the drugs given to Mrs RICHARDS were recorded on her records. **(26)** BEED consulted with Dr BARTON on **18th August**. They were both of the opinion that the patient was deteriorating, and that the drugs as prescribed were not controlling the pain. They were of the opinion that she was going to die shortly, that rehabilitation was not an option, and that a syringe driver was the only way to control the pain. **(28)** BEED consulted with the family, who were in agreement with this course of action. **(31)** That decision was taken by BEED, Dr BARTON and Margaret COUCHMAN, in consultation with the family. **(35)** Although Midazolam is not licenced for subcutaneous use, it is commonly used in that way in palliative care. **(37)** Mrs RICHARDS was not given fluids because studies have shown that there is little benefit in giving fluids in those situations. **(38)** Although not recorded in the notes, Mrs

Syringe driver ~~[illegible]~~ started by Beed + Couchm.

RICHARDS would have been monitored regularly between the **17th** and her death. **(40)** Despite the fact that Mrs RICHARDS appeared to be pain free, the dosages were kept at the same level, as is common practice with a patient who will not recover. Mrs RICHARDS was such a patient.

5th interview

(1) In any event there is an entry in the records by Staff Nurse JOYCE saying that Mrs RICHARDS was in pain when she was moved. **(2)** The doses she was on were not the maximum. The overall picture was of a lady in severe pain. Death would have endued within a short time. **(3)** Dr BARTON records that the cause of death is actually bronchopneumonia. Certainly Mrs RICHARDS had a very rattly chest. **(5)** The regime of drugs that Mrs RICHARDS was on would not necessarily kill all people subjected to that regime of drugs.

Palliative care is when it is recognised that someone is dying [handwritten annotation]

(8) BEED remembers a conversation with Mrs MacKENZIE concerning euthanasia. BEED made it clear that it was not something that they either could or would do. **(9)** A patient receiving palliative care such as Mrs RICHARDS would not properly be able to absorb fluids if given subcutaneously. For that reason she was not given fluids. **(11)** BEED finds it puzzling that Mrs MacKENZIE and Mrs LACK are now asking numerous questions which they had every opportunity to ask at the time. He states that he spent a lot of time with them answering their questions. **(13)** Mrs RICHARDS was not transferred back to Haslar since Dr BARTON was of the opinion that she may not have survived the transfer.

Margaret COUCHMAN – 29th June 2000 (DOB 16/Nov 1935)

1st interview

(3) E grade Staff Nurse on Daedalus Ward. She takes charge of the ward. **(4)** Has been on the ward 12 years. The patients are highly dependant. **(5)** I wasn't on the ward when Mrs RICHARDS was admitted. One of the support workers, Linda BOLDECINOS came to tell me that she was worried as Mrs RICHARDS had been transferred on a sheet, rather than a canvas, wasn't happy with the way she was lying, and thought she was in pain. **(6)** I went, introduced myself to the daughters who were there, and one of them helped me put their mother into a more appropriate position. Mrs RICHARDS was also having trouble eating.

(7) I asked the daughters if they would agree that she be given a painkiller. They agreed, and so I spoke to Philip BEED, who agreed that she be given some Oramorph. **(13)** We were told that the daughters were suing the nursing home at which Mrs RICHARDS had broken her hip. We therefore bent over backwards to try and prevent a complaint, which we would do anyway. We were conscious that something like this could occur. **(14)** One of the support workers became friendly with one of the daughters, Mrs MacKENZIE, who was interested in Spiritual Healing. Three of the ward went to a meeting addressed by the National Federation of Spiritual Healers, held about six to eight weeks after Mrs RICHARDS' death. **(15)** At the meeting she said that she was unhappy with the standard of nursing care that her mother had received on the ward. **(16)** She gave members of the

ward staff books as presents. She also donated her Mother's easy chair from the nursing home as a present to the ward.

(19) When she came onto the ward, we were aware that Mrs RICHARDS was deaf in both ears, had had a cataract operation on both eyes, had had a six month history of falls, had Alzheimer's. **(20)** The Alzheimer's affected her speech and memory. She also cried out frequently. She needed the attention of her daughters frequently. **(21)** There was nothing she could do herself. **(22)** As is confirmed by the controlled drug register, COUCHMAN administered Diamorphine on the 18th and 20th August. **(25)** The decision to administer those drugs would be taken by "the whole team", which included the relatives. The formal consultation would be between Dr BARTON and the relatives, but the nursing staff would have to be consulted, since they have to administer the drugs. COUCHMAN was not present during the formal consultation. **(26)** However, COUCHMAN can authorise the administration of controlled drugs, **(27)** once they have been prescribed by Dr BARTON. **(29)** Similarly, with the syringe driver, COUCHMAN could authorise the use of it, but only after the drugs had been prescribed by Dr BARTON. **(31)** COUCHMAN, if accompanied by another qualified member of staff, may administer Diamorphine. **(32)** COUCHMAN cannot recall any conversations between BEED, Dr BARTON and the family about the use of the syringe driver. **(33)** Nor can she remember any representations made by the daughters that such a course should not be taken. In any event, none were made to her personally, and as far as she was aware, the daughters' only concern was that their mother should not be in any pain. **(36)** Ultimately Dr BARTON is the person who decides whether or not to use a syringe driver. **(37)** However, we would not administer a drug which we did not consider

necessary, even if it told to do so by a doctor; **(38)** we would speak to someone else, or our Union representative.

(40) When Mrs RICHARDS was put on the syringe driver, COUCHMAN's impression was that she was not dying. She drew the conclusion that Mrs RICHARDS was dying a couple of days before she did, in fact, die. **(42)** When Mrs RICHARDS was transferred back from Haslar on the 17th August, one of the daughters mentioned that a Doctor at Haslar had said that she should go back if her hip came out again, rather than that she should go back to Haslar if she were in pain. It is possible that the haematoma could have been caused by the way she was transferred from Haslar.

2nd interview

(2) By the time COUCHMAN realised that Mrs RICHARDS was dying, the patient was very poorly, with a chest infection. **(3)** On 20th August, COUCHMAN administered Hyoscine, Midazolam, Diamorphine and Haloperidol. She put up the driver on that day. **(6)** They were all administered in quite low doses. We could, however, have increased the dosage without further consultation with Dr BARTON. **(9)** The drugs administered are quite a common combination. **(11)** The dosage of the Oramorph was increased. **(12)** The drugs were all licensed for subcutaneous use. **(12)** All of the prescriptions are checked by a pharmacist who comes to the hospital from Queen Alexandra hospital every Thursday. **(13)** Therefore if there is a combination which could be problematic, it would be picked up. **(14)** The pharmacist is called Jean DALTON. All of the nurses do study

days on the ward for all staff. **(15)** There are also instructions for the use of the syringe driver on the door to the room which contains the controlled drugs.

(18) There exists a statement from Sue HUTCHIN, a Manager at the hospital, in which HUTCHIN details a conversation between HUTCHIN and COUCHMAN. The Officer confirms that COUCHMAN as an individual has not been complained about. **(20)** On Mrs RICHARDS' admission to the hospital, the form was not completed because no conversation could be initiated with the patients. **(22)** COUCHMAN explains the Bartel score, and states that Mrs RICHARDS was totally dependent on admission. **(24)** Her score in total indicated that she was a very high risk patient. When admitted, she was on Lactalose and Haloperidol. **(25)** The addition to the patient's notes – regarding the fact that she was carried in on a sheet rather than a canvas – was made on the same day. It had been brought to COUCHMAN's attention by the support staff. **(29)** Although COUCHMAN's name is at the top of the form, she would not be responsible for the patient when she was not there; that responsibility would fall to the other members of her team or even to another team. When she was there, however, she would be the point of contact for members of the family.

(31) COUCHMAN is questioned about why there are gaps in the notes. She accepts that the form should have been filled out, but it was not between Mrs RICHARDS' readmission on 17th August and 21st August. **(34)** COUCHMAN was aware that the daughters had mentioned to the staff that Haslar were prepared to take Mrs RICHARDS back. That is why COUCHMAN arranged for the x-ray on the 17th August, so that she could determine whether there was any need for the patient to return to Haslar. **(35)** COUCHMAN is not qualified to assess the x-rays. That task falls to Dr BARTON, or the

radiologist. **(37)** The only circumstances in which nursing staff would not give food or drink to a patient would be when it would harm them. For example, if they were unable to swallow, or if we thought that there was a possibility that it would get into their lungs and kill them. I/V drips are another way of providing fluids, but I/V drips are not used on Daedalus Ward. **(38)** Fluids can also be administered subcutaneously, but at that time that was not the practice on Daedalus Ward, or indeed anywhere in the Trust. **(40)** However, if a patient were dying, fluids would probably not be administered. **(41)** Medical opinion will tell you that there is research that people in that position may be more comfortable without the subcutaneous administration of fluids.

Christine JOICE – 15th June 2000 (17 Dec 1950)

(4) RGN, qualified in 1989. She has worked almost solely with the elderly since that time, most of that time at Gosport War Memorial Hospital. Has worked on Daedalus Ward since it was first opened. **(5)** The syringe driver is used to administer morphine in lots of cases; it is the best option for relieving pain when patients are near to death. **(6)** The syringe driver would be used in preference to oral drugs if, for example, they are unable to swallow, or are otherwise unconscious. A syringe driver is always administered subcutaneously. **(8)** The nursing staff have yearly syringe driver updates, to refresh their knowledge of how they work.

(10) On Daedalus Ward, Dr BARTON would prescribe the medication. We would use our knowledge to advise Dr BARTON, but nurses cannot prescribe medication. **(11)** If Dr BARTON were not available, one of her partners would do the ward round. They include

Dr PETERS, Dr BEASLEY, Dr BRIGG and Dr BROOKS. **(13)** Because all the patients are very dependant, the ward is very hectic. **(14)** Normally there were 19 or 20 people on the ward. **(15)** Mrs RICHARDS was very poorly when she was admitted, and would cry out a lot. It was difficult to say whether that was through pain or dementia. JOICE remembers little about her nursing care. She wasn't involved with her very much as she wasn't one of "her" patients. She spoke to the daughters on a few occasions, and remembers that they were not happy with the treatment their mother was receiving, as she had fallen from her chair whilst in the hospital. **(16)** JOICE was on duty when she fell (**14th August**) but wasn't involved in the incident.

(17) JOICE recalls that when Mrs RICHARDS was transferred back to the hospital on the **17th August**, she was crying and screaming. BEED came on duty at about 12.15 p.m. that day. JOICE cannot remember much after that. She cannot remember who was in charge of Mrs RICHARDS. **(19)** JOICE remembers Mrs RICHARDS being brought in on a stretcher. **(20)** She was never involved in or present during any discussions with Dr BARTON or any other doctor about what treatment would be best for Mrs RICHARDS. Any information about a patient would be written down and then handed on to the next shift.

(22) JOICE was of the opinion that the daughters had a different view of their mother's health from that of the nursing staff. They believed that she could do a lot more than she actually could. We found that she could eat or drink or could hardly stand up, despite what Haslar had written on the transfer notes. **(23)** She was a very ill lady right from the first admission. Dr BARTON would do a ward round every day Monday to Friday. If necessary Dr BARTON or one of her partners could be contacted at the weekend. **(24)**

The nursing staff would discuss each patient with the doctor every morning. Each patient was constantly assessed by the nursing staff.

(28) On the prescription chart there is an indication that Oramorph was prescribed. In addition, there was an instruction from Dr BARTON that Diamorphine was to be administered if required. The chart does not show that it was ever administered. Hyoscine and Midazolam were also administered through the syringe driver. **(31)** Matcholose – a laxative – was also administered, along with Haloperidol, a calming drug. **(32)** The syringe driver was administered on the **17th August**. It contained Hyoscine, Diamorphine and Haloperidol. The note also shows that she was too drowsy to take drugs orally on **18th August** and the syringe driver was administered at 6 p.m. on that day. **(35)** The prescription for Oromorph was stopped on the **18th August** and the chart shows that Diamorphine was administered on the **19th August**. [*This section is unclear from the interview, but it appears that the 4 drugs in the syringe driver were Diamorphine, Haloperidol, Hyoscine and Midazolam.*] **(36)** The dosages are quite low and JOICE had no concerns about that combination of drugs. **(37)** The effect of the drugs is that she would be comfortably asleep.

2nd interview

(1) The amounts in the syringe driver were the bare minimum that we could have given her. In severe cases the dosages can become much higher, as high as necessary to relieve pain. The dosage administered to Mrs RICHARDS was at the bottom of the scale. **(2)** The combination of all of the drugs was sufficient to make her sleep, pain free. JOICE

does not know whether Mrs RICHARDS was conscious at any time after the syringe driver was administered.

(3) JOICE administered the syringe driver on **21st August** at 11.55 a.m. She does not remember in what condition Mrs RICHARDS was on that day. Each patient is continually assessed, and were anything wrong, JOICE or any other nurse would contact a doctor. **(7)** The nursing staff have some flexibility in administering drugs. A prescription will suggest a maximum and a minimum. If the nurses feel that they want to increase the dosage above the maximum, they must contact a doctor. **(8)** In the case of the Diamorphine, Mrs RICHARDS was given 40 mgs on each occasion. The range prescribed was between 40 and 200 mgs. **(9)** The controlled drug register must be filled out by law, and two registered nurses must be present to check the amount being administered. The register is to account for the controlled drugs going in and out.

(11) On **21st August** JOICE administered 30 mg of Diamorphine at 11.50 a.m. and 10 mg at 11.55 a.m.

(14) JOICE is unable to say whether or not attempts were made in those last few days to give Mrs RICHARDS any food or water. She does not recall any discussion or decision made about subcutaneous hydration. Nor was she concerned about Mrs RICHARDS' hydration.

(15) In general, the nurse acts as the patient's advocate, and so if she had felt something was wrong she would have gone to Philip BEED in the first instance.

(16) JOICE made the first entry in the notes when Mrs RICHARDS was transferred from Haslar on **17th August**, noting that the patient was very distressed and in pain.

(18) It would be the responsibility of whoever was assigned to a particular patient to look after that patient's cleanliness and hygiene. **(19)** JOICE doesn't remember ever being assigned to look after Mrs RICHARDS. The form does not state that she was ever so assigned, but it may be that it was overlooked.

(21) The notes state that on **18th August** at 8 p.m. JOICE made an entry stating that Mrs RICHARDS was peaceful and sleeping, but that her daughter was upset and angry about her mother's condition. The daughter appeared, however, to be happy that her mother was pain free. She cannot remember the specific nature of the daughter's concern, but notes that 'she wasn't really happy a lot of the time'. JOICE again states that the daughters' evaluation of their mother's state was more optimistic than the nursing staff's.

(22) Another entry made by JOICE on **21st August** at 12.13 p.m. states that 'patient's overall condition deteriorating, medication keeping her comfortable, daughters visited during morning'. JOICE states that, although there had been a change in condition, she felt no need to contact wither Dr BARTON or BEED. **(24)** She does not think that there was anything that could have been done at that stage to alter the fact that Mrs RICHARDS was dying.

JOICE is able to certify that a patient has died, but not give a cause of death. **(25)** The procedure would then be that she would inform the doctor that the patient had passed away, and lay out and label the body. She is unable to say what happened in Mrs RICHARDS' case, since she was not present. **(27)** The death would also be recorded in the medical notes. **(28)** An entry need only be made in either the medical notes or the contact record if something of note had happened to the patient. That explains why there are some days during which no entry was made in Mrs RICHARDS' notes.

(29) A course of palliative care, that is a course of care designed to make the patient more comfortable, was begun in respect of Mrs RICHARDS on the **19th August**, when the syringe driver was set up. Prior to that, pain relief had been given orally, in the form of Oramorph. **(31)** JOICE cannot say whether or not a decision was taken on the **19th August** to commence such a course, in the expectation of Mrs RICHARDS' imminent death, since she was not party to any such decision. **(32)** There were times when she couldn't swallow anything, and that may have been a reason to administer the analgesic via the syringe driver rather than orally. The course of treatment given to Mrs RICHARDS on **18th August** was the sort of treatment appropriate for someone in pain, and for whom nothing more can be done except making her comfortable. **(33)** On the **18th** and **21st August**, when the drug charts show oral medication, JOICE confirms that, in fact no oral medication was given.

(35) On the **18th August**, JOICE makes an entry in the notes to the effect that Mrs RICHARDS appears to be in pain. JOICE does not know whether the pain was physical, or linked to dementia, and she does not know whether anybody attempted to locate the source of the pain. **(36)** Nor does she remember any conversations with the daughters between the **17th** and **21st August** regarding the possibility of their mother returning to Haslar. **(37)** JOICE was aware that Mrs RICHARDS had a haematoma. However, she was not aware of any discussions with or between Dr BARTON and/or BEED about what to do about the haematoma.

(39) In general it was BEED who was overseeing the case. JOICE was more involved in other cases at the time.

(40) There are not resuscitation facilities available on Daedalus Ward. The procedure would be to call an ambulance. Nursing staff are trained to resuscitate, but in ten years at Daedalus Ward, JOICE has never attempted resuscitation.

(41) In summary JOICE's impression of Mrs RICHARDS is that, from the beginning of her admission, she was in pain, suffering from dementia and was 'very poorly'. JOICE concedes that she reacted well to her daughter, who spent a lot of time with her.

The legal framework

30. It is beyond dispute that the administration of diamorphine brought about Mrs Richards' death. It is also probable that it hastened her demise. What must be considered is whether those actions give rise to criminal culpability for (i) murder or (ii) manslaughter.

Murder

31. The present case shares many similarities with the famous case of Dr Bodkin Adams ([1957] Crim. L.R. 365). In Adams, Devlin J. stated the orthodox view that to shorten life by days and weeks is to cause death no less than shortening it by years, but he added that a doctor "*is still entitled to do all that is proper and necessary to relieve pain and suffering even if the measures he takes may incidentally shorten life*".

32. The issue has a profound ethical, as well as legal, dimension. Professor Ashworth's analysis of judges' attitudes to this 'defence' is of great assistance (*Principles of Criminal Law*, 3rd ed., (1999), pp. 154-5). Professor Ashworth refers to the decision in *Gillick v. West Norfolk and Wisbech Area Health Authority* [1986] A.C. 112, *Re F* [1990] A.C. 1, and *Airedale N.H.S. Trust v. Bland* [1993] 1 All E.R. 821. He argues that the approach of the House of Lords to the covert defence of 'clinical necessity' is "juristically clumsy", and stretches established legal principles of causation and intention. The substance of the 'defence', he argues, is founded in the realm of culpability. He draws attention (at p.181) to the speech of Lord Scarman in *Gillick*:

> "*the bona fide exercise by a doctor of his clinical judgment must be a complete negation of the guilty mind.*"

33. The point is not decided in the recent case of N.H.S. Trust A v. M [2001] 2 W.L.R. 942, since in that case Dame Elizabeth Butler-Sloss P. draws a distinction between omission (withdrawal of treatment of feeding from patient in permanent vegetative state) and act (the administering of drugs) and expressly declines to consider the culpability of an 'act'.

34. Nor is the point authoritatively decided by the judgment of Ward L.J. in *In re A* (Children) (Conjoined Twins: Surgical Separation) [2001] 2 W.L.R. 480. Nevertheless, support for the view that no criminal liability attaches is found in Ward L.J.'s analysis of the law as it applied to clinicians at pp. 530-537 and Brooke L.J.'s analysis of 'the doctrine of double effect' at pp. 549 et sqq.

35. Applying these principles to this case, I am of the opinion that Dr Barton's actions cannot amount to murder.

36. For the reasons expressed in N.H.S. Trust A v. M, I am also of the opinion that there is no breach of Article 3 of the E.C.H.R.

'Manslaughter by gross negligence'

37. It is difficult to see how the facts of this case could give rise to liability for manslaughter by gross negligence, not least because of the complications attached to what fault element is required in law for manslaughter under this heading: see R. v. Adomako [1995] 1 A.C. 171 and A-G's Reference (No. 2 of 1999) [2000] 3 W.L.R., and Blackstone's (2001 ed.) B1.38-39.

38. Also, a careful distinction must be drawn. It is not a grossly negligent act (like that of the anaesthetist) which has caused Mrs Richards' death: Dr Barton fully intended that the drugs be administered, and no fluids given. The only thing that *could* be characterised as grossly negligent is the *decision*, or, to pose it as a question: was the diagnosis of Mrs Richards by Dr Barton, and the consequent

decision to administer the drugs 'so bad in all the circumstances to amount to a criminal act or omission'?

39. I am of the opinion that the subcutaneous administration of drugs not licensed for administration in that way is a 'red herring'. No causation could be found between the administration of those drugs and Mrs Richards' death.

40. What remains is the decision to administer the diamorphine. Whether or not *criminal* liability will attach to that decision is really a matter of fact, given the test proposed by Lord Mackay in *Adomako*. I am of the opinion that Dr Barton took a *bona fide* clinical decision that Mrs Richards' condition had reached a stage at which was required was *palliative* care. That palliative care involved administering morphine, with the incidental, but inevitable result, that Mrs Richards' demise was hastened.

Beed told Lack on morning of 18th that her mother had developed a massive haematoma.

(xi) despite this, on 18th August 1998, Dr Barton did not seek any other medical opinion but prescribed **diamorphine**, **midazolam**, **haloperidol** and **hyoscine** to be given continuously subcutaneously over periods of 24 hours; Dr Barton told Lack this treatment was to treat the dear mother & said words to the effect "And the next thing will be a chest infection."

- not licensed

not licensed! for subcut admin

(xii) during this period, when a syringe driver was being used to administer the subcutaneous drugs, there is no evidence that Mrs Richards was given fluids or food;

19 Aug - kidney failure

(xiii) there is no evidence that either Dr Barton or any of the three nurses, Mr Beed, Ms Couchman and Ms Joice reviewed Mrs Richards' clinical condition from 18th August to determine if any reduction in the drug treatment they were administering was indicated;

No doctor's notes 18 - 21 Aug.

(xiv) the subcutaneous administration of drugs by syringe driver continues without modification and during every 24 hours from 18th August until Mrs Richards' death on 21st August 1998;

(xv) there is no clinical or pathological evidence to support Dr Barton's conclusion that death was due to bronchopneumonia.

Lack 'strongly believes that mother did not have a rattly chest or other symptoms of bronchopneumonia

The drugs involved

8. Diamorphine, also known as heroin, is a powerful opioid analgesic.

9. Haloperidol is used in the treatment of psychoses, and is also used for the short-term management of agitation and excitement.

10. Midazolan is a sedative which 'has to be used with caution in elderly people'.

Lack accepts that her mother was unwell and that her physical reserves had been depleted

Mackenzie says that they were under no illusions ? regarding her chances of survival bearing in mind her age.

11. Hyoscine is a drug used to reduce secretions and it also provides a degree of amnesia and sedation, and has an anti-vomiting effect.

12. It is important to note that neither Haloperidol not Midazolam is licensed for subcutaneous administration.

Professor Livesley's conclusions

13. The relevant outline of Prof. Livesley's conclusions, at page 16 of the report, is as follows:

    (i) Mrs Richards was capable of receiving oral medication for the relief of the pain she was experiencing on 17th August 1998;

    (ii) despite this and without consultation with any other medical person, Dr Barton prescribed the continuous subcutaneous administration of diamorphine, haloperidol, midazolam, and hyoscine;

    (iii) no other event occurred to break the chain of causation and Mrs Richards' death was directly attributable to the administration of the drugs she continuously received by syringe driver from 18th August 1998 until her death on 21st August 1998;

    (iv) without the induction of stupor and unconsciousness due to the continuous subcutaneous administration of prescribed drugs it is beyond reasonable doubt that Mrs Richards would have lived longer before succumbing to illness;

    (v) without the withholding of appropriate quantities of food and water it is beyond reasonable doubt that Mrs Richards would have lived longer before succumbing to illness.

OUTLINE CHRONOLOGY

29th July 1998	Mrs Richards suffers fall at "Glen Heathers" nursing home Admitted to Royal Hospital, Haslar (acute general hospital in Gosport) X-rays reveal broken neck of right femur Given morphine / cyclizine at 22.00 to relieve pain
30th July 1998	A surgical operation is carried out to give Mrs Richards an artificial hip
11th August 1998	Transferred to Daedalus Ward, War Memorial Hospital part of Portsmouth Healthcare NHS Trust.
13th August 1998	Suffers fall at War Memorial Hospital
14th August 1998	Readmitted to Royal Hospital, Haslar Found to have dislocated right hip, manipulated back into place Dr Barton recorded 'is this lady well enough for another surgical procedure?'
17th August 1998	Returns to Daedalus Ward, War Memorial Hospital
21st August 1998	Dies; Mrs Richards was then cremated

14. It follows that any advice on criminal liability should concentrate on the events from the 18th August until Mrs Richards' death on the 21st August. It may become necessary to consider events before the 18th August, especially to examine Dr Barton's previous knowledge of Mrs Richards' prognosis. Initially, however, the decision to administer the drugs on the 18th August, and their continued administration must be examined since it follows that, if no criminal liability attaches to those decisions, no liability will arise from the previous events.

The evidence of Mrs Lesley Lack – an outline

15. Mrs Lack acknowledges that her mother had been suffering from the onset of dementia.

16. She was unhappy with the care her mother had been receiving at the nursing home and had made the decision that her mother would not return there were she to have recovered from her surgery to a sufficient degree to be discharged from hospital.

17. Following the operation on 30th 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.

18. Following her mother's transfer to War Memorial Hospital on 11th August, Mrs Lack kept notes of areas which were of concern to her in the treatment her mother was receiving at War Memorial Hospital. 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 voice her concerns, that complaints should be in writing.

19. On 12th August 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 no cause for the anxiety was investigated.

20. At the hospital on 13th August, she was informed that her mother had fallen from a chair.

21. She was transferred back to Haslar on 14th August, the hip was manipulated back into place, and Mrs Lack noticed that her mother appeared to be recovering.

22. *It is a feature of Mrs Lack's evidence that she wishes to draw a distinction between the (apparently high) standard of care received at Haslar and the care received at War Memorial Hospital. As she says, "the issue I wish to highlight... is that when my mother's condition was correctly diagnosed and treated he pain and discomfort were removed and she recovered well".*

23. She notes that on her return to War Memorial Hospital on 17th August her mother was lying in a position which caused her great pain. She notes that, again, the source of the pain was not investigated.

24. She records that, on the 18th August 1998, when the workings of the syringe driver were explained to her, she told the Ward Manager, "just let her be pain free". She denies, however, that in 'agreeing' to the use of the syringe driver, 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".

25. She notes that she was shown correspondence from Dr Lord, the consultant, which says that she "did not attend Mrs Richards at all".

Mrs Lack says that her mother may have shown signs of anxiety + this was misinterpreted as pain.

(iii) on 11th August, having been seen by a consult geriatrician, Mrs Richards was transferred for rehabilitation to Daedalus ward; at Gosport WM Hospital

(iv) later on 11th August, Dr Barton sees Mrs Richards. She records that Mrs Richards was not obviously in pain but despite this prescribes **oramorph** [an oral morphine preparation] four hourly orally. She also prescribes large dose-ranges of **diamorphine, hyoscine** and **midazolam**. These were to be given subcutaneously and continuously over periods of 24 hours for an undetermined number of days;

(v) at the end of her case note, Dr Barton wrote 'I am happy for nursing staff to confirm death';

(vi) although prescribed, these drugs were not administered at that time;

On 12 Aug Lack says she could not rouse mother because she had been given oramorph for pain

(vii) on 13th August 1998 Mrs Richards artificial hip joint became dislocated; She was obviously in pain.

(viii) on 14th August 1998 Dr Barton arranged for Mrs Richards to be transferred back to Haslar Hospital where the dislocation of the hip was reduced;

Sat. 15 August regained consciousness at low dose + amount of analgesia

(ix) on 17th August 1998, Mrs Richards was returned to War Memorial Hospital on a sheet, rather than a stretcher. She was very distressed when she reached Daedalus ward; and complained of being in pain

discharge notes from Haslar refer to care for next 4 weeks to ensure her progress

(x) despite her distress, there is no evidence that she had any specific life-threatening and terminal illness that was not amenable to treatment and from which she could not be expected to recover;

She was x-rayed that afternoon and although no dislocation was shown she was clearly in pain.

Dr Barton said that she would be given oramorph for pain at 4 hourly intervals + position reviewed the next day.

Dr Barton thought it inappropriate to send her back

26. Mrs Lack draws attention to a Discharge Letter from Royal Hospital Haslar, to which she attaches significance, which relates to her mother's condition on 17th August and reads, "she can, however, mobilise fully weight bearing".

27. She also wishes to draw attention to the fact that there are no Doctor's notes from the 18th-21st August.

Dr Barton's interview (Code A)
qualified 1972 at Oxford University with degrees MA BM BCH.
1988 took up post of clinical asst in Elderly Medecine on a part time basis

28. Dr Barton voluntarily attended Fareham Police Station on 25th July 2000 where she was interviewed by DS Sackman and DC Colvin. During the interview she read a lengthy prepared statement which contained the following points:

(i) upon admission on 11th August, Dr Barton was of the opinion that, because of the 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;

She wrote a prescription for a number of drugs which would allow nursing staff to respond to Mrs Richards' needs as the clinical assessment

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

(iii) when she was transferred back to War Memorial Hospital on 17th August, Dr Barton was unaware that Mrs Richards had been on intravenous morphine until shortly before her transfer. This explains her apparent peacefulness upon transfer;

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

GWMH has 48 long stay beds & Dr Barton would carry out 5 clinical asst sessions. One each weekday morning.
See para 6 of statement.

Considered that further transfer of such a frail unwell elderly lady was not in her best interests and was inappropriate

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

(vi) she confirms that she spoke to the daughters, 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 medicines by mouth".

(vii) she believes she would have mentioned the inappropriateness of the subcutaneous administration of fluids, on the grounds that it would not have been in her best interests and could have caused her further pain and distress;

(viii) she confirms that there were no facilities for administering intravenous fluids at War Memorial Hospital;

(ix) she had seen no evidence of Mrs Richards' supposed sensitivity to morphine;

(x) on the morning of the 19th August, Dr Barton [reviewed Mrs Ri condit with senior trained staff a] considered that Mrs Richards has a "rattly" chest and had developed bronchopneumonia; that is why she prescribed the hyoscine;

(xi) there was no significant change in Mrs Richards' condition when she saw her on the morning of 20 August;

(xii) following Mrs Richards' death, she discussed the case with the Coroner's Officer, a police officer at Cosham Police Station. The death

Gladys Mabel Richards – Interview summaries

Dr Jane BARTON – 25th July 2000

See Dr BARTON's statement read in interview.

Philip James BEED – 24th July 2000 (DOB Code A)

1st interview (Fareham Pol. Station)

(2) Clinical Manager – Charge Nurse in charge of Daedalus Ward at Gosport War Memorial Hospital ('GWMH'). (3) He has 24 hour accountability for the nursing care of the patients on the ward. He has been nursing for 20 years having trained in the Royal Navy, and has worked at BUPA hospital in Havant and Oxford Radcliffe Infirmary. He has no specific training in the care of the elderly, (4) but considerable experience of working with elderly patients. At GWMH, there is no on site medical cover.

(5) Consultant in charge is Dr LORD. She conducts a ward round twice a week, and is contactable at other times on the telephone. (6) The clinical assistant is Dr BARTON, who comes in daily Monday to Friday. (7) GWMH takes admission from other hospitals, and (8) assesses them to see what can be done in terms of rehabilitation. There are twenty-four beds on the ward. On duty with Dr BARTON are 5 trained staff and 11 health care support workers. (9) It's often busy and if all of the patients require attention, (10) it can become very pushed.

The hierarchy is as follows: Dr LORD in overall charge; then Dr BARTON; then BEED; then registered nurses and auxiliaries. **(11)** Dr LORD, Dr BARTON and other doctors in Dr BARTON's practice are responsible for prescribing the drugs that are used on the wards. **(14)** A pharmacist, Jean DALTON, also visits once a week; she also advises on medications. **(15)** BEED also would know when something isn't proper. If a less well known drug is used, then he would look it up in the BNF. That is part of his normal routine before giving the drug to the patient. **(16)** Anybody can point it out if they think something's wrong.

(26) A syringe driver works by delivering a dose of soluble medicine subcutaneously over a 24 hour period. **(27)** It is used most commonly for pain control, sedation and control of secretions, most often when they are receiving palliative care. It is used to provide a continuous amount of pain relief, and the dose can be increased or decreased. **(29)**

Palliative care is concerned with making sure that someone who is dying is comfortable, pain free, clean and dignified. **(30)** With experience, it is fairly easy for the medical and nursing staff to recognise when someone is dying. **(31)** The nursing team is empowered to initiate a syringe driver if necessary without consultation with a doctor. **(32)** The use of a syringe driver is usually, but not always, a signal that palliative care is being instituted. **(33)** Patients can come off a syringe driver, but that would be unusual. **(38)** If anything significant happens to a patient, it is recorded on her medical record, at least in summary.

2nd interview

Syringe driven in use about 10 · 15yrs.

(1) If Dr LORD wasn't present, there was just clinical assistant cover. If the advice of a consultant were required, we would telephone one at Queen Alexandra's Hospital. (2) Dr LORD was present on the ward when Mrs RICHARDS was first admitted, on the day she fell from her chair. There were no plans for Dr LORD to examine her. It retrospect it would have been helpful, but falls are not uncommon. (6) Dr BARTON comes in every morning for about 20 to 30 minutes. The nurse in charge will talk to her about all of the patients, and how they've been in the last 24 hours. If a particular patient needs to be seen, Dr BARTON would examine the patient. (7) She would not see every patient every day, only those identified by the nurses as requiring attention. The doctor relied on the nurses' judgment.

(9) There is a great deal of trust between BEED and Dr BARTON. They have worked together for 3 years. (15) When Mrs RICHARDS was transferred on **11th August** she was very confused, very agitated. She had come to us for assessment and gentle rehabilitation. (16) Her prospect of regaining mobility was limited because of her confusion, her poor hearing and her history of falls. She was also clearly in pain, and was given Oramorph by BEED and another nurse, Monica CRAWFORD. Mrs RICHARD's daughter came in that afternoon, and said that when she was agitated it was because she wanted to go to the toilet. (17) She certainly wasn't able to communicate very effectively. She had a further dose of Oramorph at 11.45 p.m., given by Staff Nurse MARJORAM and a further dose at 6.15 a.m. the next morning. BEED then came back to work on the Friday, starting at 7.30 a.m., and was told that Mrs RICHARDS has fallen from her chair the previous day.

At first it appeared that there had been no injury, but later that evening it was noticed that the hip appeared to be dislocated. The nurse in charge that evening had contacted the duty

doctor whose advice has been to keep her comfortable that night and arrange for an x-ray the following morning. **(18)** The x-ray confirmed that the hip had been dislocated, and so arrangements were made to transfer her back to Haslar with a view towards having the dislocation reduced under sedation. He spoke to Mrs LACK to explain what they planned to do. Mrs RICHARDS was then given more Oramorph.

(19) BEED was aware that Mrs LACK was angry about the fact that her mother had dislocated her hip and that there had been a delay in when the dislocation had been noted, and when it had been x-rayed and treated. At this point BEED was aware that he felt that he was not only looking after Mrs RICHARDS but also her daughters. He could see that they could be quite angry and difficult. **(20)** When Mrs RICHARDS returned from Haslar, her daughter was there saying, "why is mum uncomfortable and what's going on". BEED envisaged problems both with Mrs RICHARDS and her family.

(21) BEED has problems remembering the exact sequence of events. Mrs RICHARDS settled down when Dr BARTON checked her into the hospital, but after Dr BARTON left the ward, she was screaming in pain and distress. BEED contacted Dr BARTON, who advised a further x-ray of the hip. Mrs RICHARDS was given more Oramorph at about 1 p.m., and then was again x-rayed. The daughters were upset that they weren't allowed into the x-ray room. The x-ray revealed that there was no further dislocation.

(22) Mrs RICHARDS was refusing to eat or drink, was still in considerable pain and distress, and was given more Oramorph at 1.00 / 3.15 / 4.45. It was agreed with the family that the priority was to keep Mrs RICHARDS pain free and comfortable.

(23) However, there appeared to be some sort of dispute between the daughters. The pain control was keeping Mrs RICHARDS comfortable, but she was still not eating and

drinking. She was reviewed by Dr BARTON the following morning (**18th August**), who was of the view that she should not be transferred to Haslar, but rather that a syringe driver should be used so that continuous analgesia could be given to keep Mrs RICHARDS comfortable. (**24**) The family agreed to this course, which was started at 11.30 a.m. that morning, and it quickly established a level of pain control which allowed staff to look after Mrs Richard properly to keep her clean & dignified (**25**) BEED was aware that Mrs LACK wanted to make a complaint about the occasion when her mother had fallen from her chair. He facilitated the making of this complaint.

(**26**) Mrs RICHARDS died on Friday night. The amount of time BEED and other nurses had to spend with the family made it difficult to keep the nursing records up to date.

3rd interview

(**8**) In the first few days on the ward, Mrs RICHARD's shouting got worse – she was clearly displaying signs of dementia. BEED is experienced in dealing with dementia. (**19**) Because there are no on call doctors in the hospital, if a patient's condition worsens, nursing staff can confirm that death has taken place, and then a Doctor actually certifies death at a later stage. (**20**) It is not unusual for a doctor to write on a patient's notes that nursing staff can confirm death. (**26**) Similarly, it is not unusual to leave the use of a syringe driver to the judgment of nursing staff, as Dr BARTON did on **11th August**. (**28**) BEED spoke to Mrs LACK, but he did not necessarily agree with her conclusion that her agitation was a sign that she needed to go to the lavatory. (**32**) When Mrs RICHARDS was admitted on **11th August**, the regime of drugs she was prescribed was not unusual.