POLICE STATEMENT OF DR JANE BARTON

1. I, am Dr Jane Barton of the Surgery, 148 Forton Road, Gosport Hampshire.

2. I am a Registered Medical Practitioner and qualified in 1972 at Oxford University with the degrees MA, BM BCh. I joined my present GP practice initially as an assistant and then as a partner. In 1988 I took up the additional post of Clinical Assistant in Elderly Medicine on a part time sessional basis. This post originally covered three sites but in due course was centred at Gosport War Memorial Hospital (GWMH). I retired from that position this year.

3. As a General Practitioner, I have a minimum full time position. I have approximately 1500 patients on my list. I conduct half of the on call responsibilities of my partners, with one night each fortnight on call and one weekend every quarter. I carry out one morning surgery every day and evening surgeries on a pro rata basis.

4. The GWMH has 48 long stay beds and is designed to provide continuing care for elderly patients. In each week I would carry out 5 Clinical Assistant sessions. When in this post I would attend the hospital every week day morning at an early hour to review patients and would conduct two formal ward rounds each week with the consultant geriatrician. At the time of my retirement from the post there were two consultants attending the wards. Dr Lord was the consultant responsible for Daedalus Ward. In August 1998, however only one consultant was in post; Dr Lord who was thus covering both wards. The other consultant was on maternity leave.

5. The consultant would ordinarily carry out two ward rounds each week; one continuing care and a Stroke round on Daedalus on a Thursday afternoon. Her other clinical commitments were on two other hospital sites, but she was usually available by telephone for advice and assistance

6. As Clinical Assistant, I was responsible for care of patients in both wards at the hospital. My work involved seeing a large number of elderly patients approaching the end of their lives and requiring continuing care from the Health Service. Many patients had undergone orthopaedic procedures following falls, whether in their own home, sheltered accommodation or

in residential care. They were transferred to our care once their acute management was completed. Many of the patients were also demented. I spent time attempting to forge a relationship with families and helping them to come to terms with the approaching death of a loved one. One of the strengths of our unit is that patients can be offered a level of freedom from pain, discomfort, unpleasant symptoms and mental distress which is much more difficult to deliver in an Acute Unit. One complication for our patients is that the act of transferring someone from one unit to another for whatever reason causes a marked deterioration in their condition, which may last for several days and is frequently irreversible.

7. In carrying out my work I relied on a team of nurses, both trained and untrained, to support the work that I did. Their attitude towards relatives and handing of the patients is crucial to the way the unit works. My work also involved providing support and guidance to my staff.

8. Mrs Gladys Richards was 91 and was admitted to the GWMH on 11.8.98. She had previously been a resident in the Glenheathers Nursing Home in Lee-on-the-Solent where she had fallen and fractured the neck of her right femur. She had been admitted to the Royal Hospital Haslar (RHH) and undergone a right hemi arthroplasty, a major orthopaedic procedure involving replacing the head of her femur with a metal prosthesis. The operation is performed to relieve pain and to give a patient a chance of walking again.

9. Following surgery she was assessed at RHH by Dr Ian Reid, Consultant Physician in Elderly Medicine at the Queen Alexandra Hospital, Portsmouth. Dr Reid provided an opinion to the Orthopaedic Consultant Surgeon at RHH, which gave some of the background information to Mrs Richards' condition. He reported that Mrs Richards had apparently been confused for some years, but was mobile in her nursing home until around Christmas 1997 when she had sustained a fall. She started to become increasingly noisy. She had been seen by Dr Banks a consultant Psycho geriatrician who appeared to have felt that she was depressed as well as suffering from a dementing illness. She had therefore been treated with haloperidol, a major tranquilliser and Trazodone, a sedating antidepressant.

10. Dr Reid reported that according to Mrs Richards' daughters she had been "knocked off" by this medication for months and had not spoken to them for some six to seven months. Her mobility had also deteriorated in that time and when unsupervised she had a tendency to get up and fall. Dr Reid understood that she was usually continent of urine but had occasional episodes of faecal incontinence. Dr Reid noted that following admission, Haloperidol and Trazodone had been stopped. According to the daughters, following the discontinuance of the Haloperidol and

Trazodone she appeared much brighter mentally and had been speaking to them at times. Dr Reid went on to say that when he had seen Mrs. Richards in hospital on 3rd August she had clearly been confused and was unable to give any coherent history. She was, however, pleasant and co-operative. She was able to move her left leg quite freely and, although not able actively to lift her extended right leg from the bed, she appeared to have little discomfort on passive movement of the right hip. Dr Reid was of the view that, despite her dementia, she should be given the opportunity to try to re-mobilise and it was his intention therefore to arrange transfer to the GWMH on Daedalus Ward under the care of his colleague Dr Lord in order to give her this opportunity.

11. The admission then took place to the GWMH on 11th August. The RHH would not have been able to keep Mrs Richards as an in patient, as her condition was not appropriate for an acute bed. Dr Reid had also recorded that Mrs Richards' daughters were unhappy with the care she had been receiving at the Nursing Home and that they did not wish her to return there. Her admission was therefore also a holding manoeuvre while it was seen whether she would recover and mobilise after the surgery. In this case she could be transferred back to a nursing home. If, as was more likely, she would deteriorate due to her age, her dementia, her frail condition and the shock of the fall followed by the major surgery, then she was to be nursed in a calm environment away from the stresses of an acute ward.

12. I assessed Mrs. Richard on admission. My admission note made on 11th August reads as follows:-

11.8.98 *Transferred to Daedalus Ward Continuing Care*
HPC Ⓡ # neck of femur 30.7.98
PMH) Hysterectomy 1955
Cataract operations
deaf
Altzheimers
0/E Impression frail hemi arthroplasty.
Not obviously in pain.
Please make comfortable.
transfers with hoist
usually continent
needs help with ADL
Barthel 2

I am happy for nursing staff to confirm death

13. In my view Mrs Richards was probably near to death, in terms of weeks and months from her dementia before the hip fracture supervened. Given her transfer from nursing home to acute hospital and then to continuing care and the fact that she had recently undergone major surgery; in addition to her general frailty and dementia, I appreciated that there was a possibility that she might die sooner rather than later. This explains my reference at that time to the confirmation of death, if necessary by the nursing staff.

14. The Barthel score is an assessment of general physical and life skill capability. The maximum score available would be 20, but Mrs Richards was so dependant that she scored only 2. She needed total care with washing and dressing, eating and drinking and was only mobile with 2 people and hoist for transfers to bed from chair etc..

15. When I assessed Mrs Richards on her arrival she was clearly confused and unable to give any history. She was pleasant and co-operative on arrival and did not appear to be in pain. Later her pain relief and sedation became a problem. She was screaming. This can be a symptom of dementia but could also be caused by pain. In my opinion it was caused by pain as it was not controlled by Haloperidol alone. Screaming caused by dementia is frequently controlled by this sedative. Given my assessment that she was in pain I wrote a prescription for a number of drugs on 11th August, including Oramorph and Diamorphine. This allowed nursing staff to respond to their clinical assessment of her needs, rather than wait until my next visit the following day. This is an integral part of team management. It was not in fact necessary to give Diamorphine over the first few days following her admission but a limited number of small doses of Oramorph were given totaling 20mg over the first 24 hours and 10 mg daily thereafter. This would be an appropriate level of pain relief after such a major orthopaedic procedure.

16. On the afternoon of 13th August Mrs Richards was found by nursing staff to have slipped out of her chair at approximately 1.30pm. I was not at the hospital or on duty at that time, and I was not made aware that day that she had injured herself. The duty doctor, Dr M. Brigg was contacted during the evening by nursing staff. He advised analgesia through the night and an X-Ray the following morning. The X-Ray Department at GWMH closes at 5.00pm and he felt that it was not appropriate to transfer and X-Ray the patient at RHH that evening. A transfer that evening would not have altered clinical management and it was left that I would review the patient in the morning. I arrived as usual early on the following morning 14th August and assessed Mrs. Richards. The report I received from the trained staff on duty that Friday morning

stated that she had slipped out of her chair the previous day. I arranged an X-Ray and discussed the position with the ward manager Philip Bede. The plan was that if the X-ray confirmed a dislocation of her prosthesis then Mrs Richards should be transferred to Haslar after confirmation with Dr Lord. The X-ray revealed that she had indeed dislocated her prosthesis. Surgeon Commander Spalding at the RHH was contacted and Mrs Richards was duly transferred back to the Haslar hospital. Although I was concerned, given Mrs Richard's overall condition and her frailty, that she might not be well enough for another surgical procedure; I felt that this clearly would be a matter for assessment by the clinicians at Haslar.

17. My notes on that occasion read as follows:-

"*14.8.98* *Sedation/pain relief has been a problem*
screaming not controlled by haloperidol
but very sensitive to Oramorph.
Fell out of chair last night
Ⓡ hip shortened and internally rotated
Daughter aware and not happy
Plan X-Ray
Is this lady well enough for another surgical procedure?"

18. I later made a further entry in Mrs Richards' records as follows:-

"*14.8.98* *Dear S. Cdr Spalding*
Further to our telephone conversation
thank you for seeing this unfortunate
lady who slipped from her chair at
1.30 p.m. yesterday- and appears to have
dislocated her R hip
hemi arthroplasty was done on 30.7.98
I am sending X-Rays across
she has had 7.5 mls of !0 mg/ in 5 ml oramorph
at midday
Many thanks"

19.. This is a copy of the courtesy referral letter I prepared to advise Surgeon Commander Spalding of the position after telephoning him. Once at RHH, Mrs Richards had a closed

reduction of the prosthesis under intravenous anaesthesia. She remained unconscious and unresponsive for approximately 24 hours during which time she was catheterised. Normally a healthy patient would wake up within minutes of the end of an Intra-venous anaesthetic (a short acting agent is used). This worrying response to the anaesthetic may well have been an indication of how ill and frail she was.

20. On 17th August it was considered appropriate to transfer her back to the Daedalus Ward at GWMH. The discharge letter from RHH to the nurse in charge gave advice as to how she was to be nursed using a canvas knee immobilising splint to prevent crossing of the legs and further dislocation of the hip as this was a strong possibility. This splint was to remain in situ for four weeks. When in bed it was advised that the hips be kept apart using pillows or a wedge, again to reduce the chances of dislocation. Despite these instructions while she was in bed, she could be stood with 2 nurses and fully weight bear. This instruction was given because when possible it is important to keep elderly patients moving. The surgeon was making it clear that if her general condition did improve then standing her out of bed would pose no dangers for the stability of her prosthesis.

21. I saw Mrs Richards when she was readmitted on the 17th August and my note reads as follows:-

17.8.98 *readmission to Daedalus from RHH*
closed reduction under iv sedation
remained unresponsive for some hours
now appears peaceful
Plan continue haloperidol
only give oramorph if in severe pain
see daughter again"

22. At the time of her arrival back on the ward Mrs Richards appeared peaceful and not in severe pain. This was however an initial judgement made on an assessment shortly after her arrival on the ward. I was concerned that she should have opiates only if her pain became a problem, and I altered her drug chart accordingly. I was not aware at that time that she had been having intravenous morphine at RHH until shortly before her transfer. This would have explained why at this time she appeared to be peaceful and not in pain. Her general condition had deteriorated as a result of the further operative procedure and subsequent transfer. For a frail, elderly and demented person, this can have a profound effect on their chances of survival. My

note "see daughters again" indicated that I should explain the position to Mrs Richards' daughters and prepare them for what I believed was to come. In my experience, transfer of an elderly frail patient in such circumstances frequently causes a set back in their condition with a marked deterioration. It can be something from which the patient does not recover.

23. I believe Mrs Richards later experienced further pain as it was necessary for the nursing staff to give Oramorph on four occasions between 1300 on the 17th and 0500 on the 18th August. During that time I was telephoned by the nursing staff out of my contracted hours and informed that Mrs Richards was very uncomfortable and might have suffered a further dislocation. I asked for another X- Ray to be arranged. It transpired that it was not possible for the X-Ray to be carried out simply on the basis of a verbal order; accordingly another GP signed the relevant form and the duty Doctor from my practice viewed an X-Ray with the consultant reporting the film. As far as I am aware he did not see the patient or write in her notes. The X-Ray did not show any dislocation.

24. I then reviewed Mrs Richard early the following morning. My entry for the 18th August reads as follows:-

18.8.98 *Still in great pain*
nursing a problem
I suggest sc diamorphine/Haloperidol/
Midazolam
I will see daughters today
Please make comfortable"

25. To my mind having seen Mrs Richard originally when she had been admitted on the 11th August there was by this stage a marked deterioration. My assessment of Mrs Richards on this occasion confirmed my view reached on readmission the previous day that she was dying. She was barely responsive and was in a lot of pain. By this time she was not eating or drinking. When I examined Mrs Richards there was a lot of swelling and tenderness around the area of the prosthesis. There was no evidence of infection at that time, and it was my assessment that she had developed a haematoma or large collection of bruising around the area where the prosthesis had been lying while dislocated. This was in all probability the cause of Mrs Richards' significant pain and unfortunately a not uncommon sequel to a further manipulation required to reduce the dislocation. This complication would not have been amenable to any surgical

intervention and again further transfer of such a frail and unwell elderly lady was not in her best interests and was inappropriate.

26. After I had seen Mrs Richards that morning and following morning GP surgery, I then spoke with her daughters in the presence of Philip Bede the Ward Manager. I explained my concern to administer appropriate and effective pain relief and that without this nursing their mother was a significant problem. They understood, but did not like the idea that diamorphine was to be given. However I explained that it was the most appropriate drug. As their mother was not eating or drinking or able to swallow, subcutaneous infusion (a tiny needle implanted under the skin) of pain killers was the best way to control her pain and by titrating the dose over 24 hours frequent injections could be avoided. Both daughters reluctantly agreed to the use of a syringe driver. 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.

27. I believe I would have mentioned fluids and explained that in my view they were not appropriate. I was aware that Mrs Richards was not taking food or water by mouth. It would have been dangerous to try to give her food or water by mouth as her poor conscious state meant that she might have choked. Mrs Richards would have had mouth care and sips of water to aid her comfort. In view of this the only alternative for further nutrition would have been to administer fluids intravenously or subcutaneously. We did not have the facilities to administer iv fluids, and accordingly to do that it would have been necessary to transfer her back to an acute unit. I did not feel that this was appropriate medically. She might well not have survived the journey let alone the process. Given my assessment that she was terminally ill, and that the actual administration of fluid would not affect that outcome, it would not have been in her best interests and could have caused her further pain and distress.

28. I believe I would have explained to the daughters that subcutaneous fluids were not appropriate. Their use would not have altered the outcome and there are several clinical studies showing this in terminally ill patients. Administration of subcutaneous fluids can cause significant tissuing of fluid and discomfort for the patient. There is a risk of oedema and infection and even tissue necrosis. If the kidneys are failing the additional fluids can overload the heart and precipitate heart failure. This would cause clinical distress and require unpleasant treatment. Given these potential complications and the fact that subcutaneous fluids would not have affected the outcome, again I did not consider it would be in Mrs Richards' best interests that subcutaneous fluids be given.

29. I also included in my discussion the opinion that Mrs Richards was likely to develop a chest infection due in part to her immobility despite regular turning by the nurses and partly due to the inadequate clearing of secretions. Antibiotics would not have been appropriate or indeed effective.

30. I said to the daughters that the prognosis was very poor and that she was not well enough for a further transfer to an acute unit. I was concerned in all the circumstances to provide an honest view.

31. When Mrs Richard was admitted to Daedalus Ward for the first time, I think it was suggested by her daughters and reported to me by nursing staff, that she might be sensitive to morphine, hence my mention of it in the clinical notes of 14.8.98. However I had seen no evidence of that when she had been given Oramorph earlier in her admission. In the first 18 hours following her transfer back from RHH she was not responding to a total of 45 mg of morphine orally in less than 24 hours. Therefore to ensure pain relief this would have to be increased. Diamorphine is a more potent analgesic than Morphine. In view of the need to increase the amount of pain relief (45mgs of Morphine in less than 24 hours having been clearly insufficient) and that Morphine (into which Diamorphine is broken down) has a relatively short half life, I consider that 40mgs of Diamorphine was appropriate for her pain relief. Mrs Richards would also have developed a tolerance to opiates through the previous administrations of Oramorph.

32. My use of Midazolam in the dose of 20 mg over 24 hours was as a muscle relaxant, to assist movement of Mrs Richards for nursing procedures in the hope that she could be as comfortable as possible. I felt it appropriate to prescribe an equivalence of Haloperidol to that which she had been having orally since her first admission.

33. I reviewed Mrs Richards' condition with the senior trained staff again on the morning of 19th August. From my assessment it was apparent that she had a 'rattly' chest and had developed bronchopneumonia. This would have been as a result of her frail condition and despite the fact that she was being turned regularly she was vulnerable to an infection developing. I did not make a note of this assessment but did prescribe hyoscine in the dose of 400 mcg and this was duly added to the syringe driver. Hyoscine is an antimuscarinic drug which is given to dry the bronchial secretions produced by the infection. This drug as with the others was reviewed and discussed daily as I visited the ward and assessed her overall condition. I am clear in my mind that there was no apparent depression of Mrs Richard's respiration. Had

there been any such depression, I would have reviewed the drug regime. As it was, Mrs Richards was apparently now out of pain and accordingly I considered the drug regime and the dose used to have been appropriate. In such circumstances, as I was not in position to attend continuously, it was necessary to have reliance on the nursing staff for reports on any problems arising. No further problems were related to me during this period. I saw Mrs Richards again on the morning of 20th August. There was no significant change in her overall condition.

34. I saw Mrs Richards again on the morning of 21st August. My note of that attendance reads as follows:-

21.8.98 *I think more peaceful*
needs hyoscine for rattly chest"

35. In my clinical opinion, by the 19th August Mrs Richards had developed bronchopneumonia. I do not believe that the dose of 40 mg of diamorphine administered over 24 hours had contributed to the development of the bronchopneumonia. It was an appropriate amount required to relieve her of her pain.

36. Sadly Mrs Richards died on 21st August, being pronounced dead at 9.20pm by one of the nursing staff. I gather that her daughters were with her when she died.

37. On the next working day, Monday , 24th of August, I discussed the case with the Coroner's Officer, a police officer at Cosham Police Station. I informed him that Mrs Richards had sustained a fractured neck of femur on the ~~13th August~~ 30th July and was subsequently operated on at RHH. I would have told him of the dislocation and the fact that she had returned to RHH and back to our care and had died on 21st August; in my view of bronchopneumonia. The Coroners Officer was happy that no further investigation was required and I signed the death certificate putting bronchopneumonia as the cause of death. I believe that this was the cause of death in all the circumstances.

38. At no time was any active treatment of Mrs Richards conducted with the aim of hastening her demise. My primary and only purpose in administering the Diamorphine was to relieve the pain which Mrs Richards was suffering. Diamorphine can in some circumstances have an incidental effect of hastening a demise but in this case I do not believe that it was causing respiratory depression and was given throughout at a relatively moderate dose.

39. Similarly it was not my intention to hasten Mrs Richard's death by omitting to provide treatment for example in the form of intravenous or subcutaneous fluids. By the 18th August it was clear to me that Mrs Richards was likely to die shortly. I believed that transfer to another hospital where she would be in a position to receive intravenous fluids was not in her best interests as it would have been too much of a strain and brought about a premature demise. There is clear evidence that the administration of intravenous or subcutaneous fluids would not have prolonged her life and faced with the complications which could arise such intervention was not in her best interests.

40. I explained the position to Mrs Richard's daughters, they did not appear to demur at the time and indeed at no time requested a second opinion.