At the request of the Coroner

SUMMARY OF CONCLUSIONS

Gladys RICHARDS
DOB: Code A
DOD: 21/08/1998

Gladys Richards presents an example of a common, complex problem in geriatric medicine. A patient with one major progressive and end stage pathology (a dementing illness) develops a second pathology, has surgery, has a complication after that surgery, has more surgery and gradually deteriorates and dies.

3. CHRONOLOGY/CASE ABSTRACT. (The numbers in brackets refer to the page of evidence, the numbers with 'H' in front are the Haslar notes).

3.1 Gladys Richards was a 91 year old lady and in 1998 was admitted as an emergency on 29th July 1988 to the Haslar Hospital (H39).

3.2 She had had a progressive dementing illness documented as short term memory loss in 1988 (435), a mental test score of 4/10 in 1994 (443) and a mental test score of 0/10 in 1996 (451). She was admitted to the Glen Heathers Nursing Home in 1994 (202) and was moderately dependent with a Barthel of 11/20 at that time (200). She was seen by a psycho-geriatrician, Dr Banks, who in 1998 found that she had end stage dementia (473). The nursing home noticed that she was wandering and very frail in July 1998 (563). The nursing home notes document multiple falls.

3.3 On admission to the Haslar Hospital, a fractured neck of femur is diagnosed and she is treated with a right hemi-arthroplasty (H50). Recovery is complicated by agitation. She is seen by Dr Reid on 3rd August (23) who notes her long standing dementia. He finds her pleasant, co-operative, with little discomfort on passive movement and she should be transferred to the Gosport War Memorial hospital to see if it was possible to remobilise her (466,467).

3.4 Her drug charts in Haslar Hospital show that no regular pain killer is given during her first admission (H110), although Diclofenac was prescribed but not given. She does receive intravenous morphine 2.5. mgs on 31st July, then single doses on the 1st and 2nd August (H114). She then receives regular Co-codamol orally, although it is written up Prn, until 7th August. After this date there appears to be no further painkillers given. between 7-12th

3.5 The nursing cardex in Haslar (H152, H167) does not mention any pain during her recovery.

3.6 She is transferred to Gosport War Memorial Hospital on 11th August and seen by Dr Barton (29) who notices her previous hysterectomy in 1953, her cataract operations, her is deafness and that she has "Alzheimer's Disease". She records that her impression is of a frail demented lady who is not obviously in pain. Despite the statement in the notes, there is no other evidence of a clinical examination, or any record, if it was undertaken. There is also no mention of pain in the medical notes until after her hip dislocation. She mentions that her Barthel score is 2 (heavily dependent), she transfers with a hoist. She also states "I am happy for nursing staff to confirm death".

3.7 The next medical note on 14th August and states that sedation/pain relief has been a problem, screaming not controlled by Haloperidol and very sensitive to Oramorphine (29). Fell out of chair last night, right hip shortened and internally rotated, daughter aware and not happy. Is this lady well enough for another surgical procedure? She has an x-ray that notes the hip is dislocated and is transferred back to the Haslar Hospital.

3.8 The nursing notes for this first admission to Gosport War Memorial Hospital state that she had a Barthel of 3/20 on admission (40). Is highly dependent with a Waterlow score of 27 (41). The nursing care plan for the 12th (49) mentions that Haloperidol was given because she woke from sleep very agitated. It mentions that on the 13th August Oramorphine is given at 21.00 (50). It mentions an x-ray needed the following morning. On 14th August pain is mentioned in the right leg in the nursing cardex (50). I find no other mention of pain in the nursing cardex.

3.9 Oramorphine 10 mgs in 5mls (62) is written up prn on admission to Gosport Hospital, two doses are given on 11th August, one dose 12th August, one dose 13th August in the evening (as confirmed in the nursing cardex) and

one dose on 14th August in the morning (as confirmed in the nursing cardex). Also on the prn side of the drug cardex on admission to Gosport on the 11th August, Diamorphine 20 – 200 mgs is prescribed subcutaneously but never given. Hyoscine 200 – 800 mgs and Midazolam 20 – 80 mgs in 24 hours subcutaneously are both written up on 11th August. Neither of these two drugs are given until her subsequent return from Haslar.

3.10 On 14th August she is transferred back to Haslar where a dislocation of a hip is confirmed by x-ray (H67) and is reduced under sedation (H67). She has an uneventful recovery and is transferred back to Gosport War Memorial on 17th August. Discharge summary mentioning Haloperidol, Lactulose, Co-codamol and Oramorphine 2.5 – 5mgs for pain (H79), although the Oramorphine was never given in Haslar.

3.11 Dr Barton writes in the notes on the 17th August after her re-admission to the Gosport War Memorial Hospital to continue Haloperidol and only give Oramorphine if in severe pain (30), and that she wishes to see the daughter again. There is no record of any assessment of Mrs Richard's mental or physical state on transfer except a statement 'now appears peaceful'. Yet the nursing cardex 17th August says patient distressed and appears to be in pain (45). In the afternoon of 17th August, states, "in pain and distress, agree with daughter to give her mother Oramorphine 2.5 mgs in 5 mls". It is possible Dr Barton only saw the patient after she had been given Oramorphine. Due to the pain, a further x-ray is ordered and no dislocation is seen (46) (75).

3.12 On 18th August, Dr Barton notes the patient is still in great pain, nursing is a problem, she suggests subcutaneous Diamorphine, Haloperidol and Midazolam and that she will see the daughters. The nursing cardex records the decision to pain control by syringe driver (46). She then receives Diamorphine 40 mgs daily in a syringe driver, with Haloperidol 5 mgs and 20 mgs Midazolam until her death on 21st August 1998.

3.13 An unusual feature of the original Gosport War Memorial Drug Chart (64) is that Oramorphine 2.5 mgs 4 hourly was written up on the regular prescription side on the 11th August, together with 5 mgs at night regularly. It then has the letters prn against both of these prescriptions which make no sense(62).

Drug	Date prescribed	Prescribed as	Prescriber	Given		
Oramorphine	11/08	10 mgs in 5 mls 2.5 – 5 mls 4 hourly Oral PRN	Dr Barton	11/08 11/08 12/08 12/08 14/08 17/08 17/08 17/08 17/08	? 1145 0815 2050 1150 1300 ? ? 2030	10 mgs 10 mgs 10 mgs 10 mgs 10 mgs 5 mgs 5 mgs 5 mgs 10 mgs

				18/08 ? 10 mgs 18/08 0400 10 mgs
Diamorphine	11/08	20 – 200 mgs S/C in 24 hours PRN	Dr Barton	Never given
Midazolam	11/08	20 – 80 mgs S/C in 24 hours PRN	Dr Barton	18/08 1145 20 mgs 19/08 1120 20 mgs 20/08 1045 20 mgs 21/08 1105 20 mgs
"PRN" Oramorphine	12/08	10 mgs in 5 mls 2.5 mgs oral 4 hourly Regular	Dr Barton	Never given or crossed off
"PRN" Oramorphine	12/08	10 mgs in 5 mls 5 mgs oral nocte Regular	Dr Barton	Never given or crossed off
Diamorphine	18/08	40 – 200 mgs S/C in 24 hours Regular	Dr Barton	18/08 1145 40 mgs 19/08 1145 40 mgs 20/08 1045 40 mgs 21/08 1105 40 mgs
Haloperidol	18/08	5 -10 mgs S/C in 24 hours Regular	Barton	18/08 1145 5 mgs 19/08 1145 5 mgs 20/08 1045 5 mgs 21/08 1105 5 mgs

4. TECHNICAL BACKGROUND / EXAMINATION OF THE FACTS IN ISSUE

4.1 This section will consider whether there were any actions so serious that they might be the direct cause, or have made a more than minimal contribution, to the death of Gladys Richards.

4.2 Mrs Richards was suffering from the terminal stage of a dementing process, probably Alzheimer's disease. This is reflected in the comments earlier in 1998 by a consultant psycho-geriatrician that she had end stage disease and the well-documented progression of this over many years. Despite this though, she was still able to get around in the nursing home and as is often the case, even with the best forms of monitoring, having multiple falls.

4.3 As a result of one of these, she suffers a fractured neck of femur. Sadly this is very common, it is also common for the original fall to lead to a partial fracture which is not diagnosed and then only subsequently sometimes hours, sometimes days later, does it become a clinically obvious fractured neck of femur. Patients with dementia and fractured neck of femur are often missed in hospitals as well as in nursing homes, even by the most astute of staff.

4.4 She has a successful hemi-arthroplasty in Haslar, receives pain relief but does not need any pain relief for the 3 days on 7th – 10th August. She remains highly dependent though with a Barthel of 3/20. Although she is described as weight bearing in Haslar, the Barthel describes no mobility at all as does the fact that a hoist is needed for transfer at Gosport War Memorial. Many patients with severe dementia, never walk again after a fractured neck of femur and indeed the mortality rate in the months after a fractured neck of femur is extremely high, particularly in the very elderly and those with mental impairment.

4.5 However, she survives the first operation and is seen by Dr Reed, Consultant Geriatrician who believes that she should be transferred to Gosport War Memorial to see if any mobility can be regained. This is not unreasonable; it may make her new placement in a nursing home easier if she is able to have some increase in independence.

4.6 When she is transferred to Gosport War Memorial Hospital she is seen by Dr Barton who fails to record a clinical examination apart from a general statement she is a frail and demented lady. However, she does state she is not obviously in pain. Despite this, she has written up her drug charts for both low dose of Oramorphine and a high dose of Diamorphine. I can find no clinical justification for these decisions in the notes. If she was worried about pain and feared that it would be hard for the nursing staff to get hold of the doctor, then it would be reasonable to write up a prn of a mild pain killer such as Paracetamol and possibly doses of weak Opioid if simple analgesia did not work. Dr Barton also writes up on the regular prescription side a significant dose of Oramorphine, although this has prn put next to it. I believe this to be highly suboptimal prescribing.

4.7 In paragraph 15 of Dr Barton's police statement (12 June 2001) she states "Given my assessment that she was in pain I wrote a prescription for a number of drugs on the 11th August, including Oramorph and Diamorhine". I can find nothing in the notes to support this statement.

In the same report (paragraph 22) Dr Barton states referring to her readmission on the 17th August that "I was not aware that she had been having intravenous Morphine at the RHH until shortly before her transfer". I can find no evidence to support this statement in the Hasler notes. The only intravenous Morphine she received in Hasler was around the time of the first operation, the last dose given on 2nd August.

Barton admitted incorrect

4.8 Oramorph is actually given by the nursing staff on 11th, 12th and 13th, certainly prior to the definite diagnosis of the dislocation. I can find no justification for giving the drugs in the medical or nursing notes. The comment on the 14th August that pain relief has been a problem, probably relates to the dislocation after the fall on the 13th. If no reason

can be documented or proven, then this is certainly very poor drug prescribing and management. Indeed to prescribe a controlled drug without a clinical indication must be considered negligent in my view.

4.9 She is identified as having had dislocation of hip by the 14th August. This probably resulted from the documented fall and is not uncommon in frail older people after a fractured neck of femur repair. The Oramorphine that had been given might have contributed in part to this, though she was also on major tranquillisers and suffering from severe dementia. All of which makes such an outcome more likely.

4.10 She then returns to Haslar Hospital. The dislocation is reduced under intravenous sedation, and she is then returned back to Gosport War Memorial. She is never right from the moment she returns. She is now documented to be in significant pain. No cause for this pain is suggested in the notes. In my view it would have been appropriate for Dr Barton to discuss Mrs Richards with the surgical team at Haslar Hospital, or with her consultant, to decide if anything further should be done at this stage. Unfortunately, not only is the mortality high after a single operation in a patient with end stage dementia but having a further operation is often an agonal event. The cause of her pain remains unexplained and when seen on the 17th by Dr Barton is "now appears peaceful". It is possible Dr Barton only saw her after she had been given Oramorphine, if this is the case it would be poor medical practice, as she would not have been reassessed as to the medical cause of her pain and distress.

Already decided she was dying on 17th

However it seems to me that it would be not unreasonable at this stage if nothing more can be done medically, to provide palliative care and pain relief. Diamorphine is specifically prescribed for pain and is commonly used for pain in terminal care. Diamorphine is compatible with Midazolam and can be mixed in the same syringe driver. Diamorphine subcutaneously after oral morphine, is usually given at a maximum ratio of 1 – 2 (i.e. up to 10 mgs Diamorphine in 20 mgs of Oramorphine). The maximum amount of Oramorphine she had received in 24 hours was 45 mgs prior to starting the syringe driver pump. Thus if her pain was not controlled, it would be appropriate to give a higher dose of Diamorphine and by convention this would be 50% greater than the previous days (Wessex Guideline) but some people might give up to 100%. A starting dose of Diamorphine of 20 – 40 mgs in 24 hours would seem appropriate. Mrs Richards was prescribed 40 mgs, which in my view is just within prescribing guidelines yet seem high for someone who had been identified as "sensitive to Oramorph" by Dr Barton on the 14th August (29).

4.11 Midazolam is widely used subcutaneously in doses from 5 – 80 mgs for 24 hours and is particularly used for terminal restlessness. The dose of Midazolam used was 20 mgs for 24 hours which is within current

guidance, although many believe that elderly patients may need a lower dose of 5 – 20 mgs per 24 hours (Palliative Care. Chapter 23 in Brocklehurst's Text Book of Geriatric Medicine 6th Edition 2003).

4.12 It was documented that Mrs Richards is peaceful on this dose in the syringe driver and a rattly chest is documented in the medical notes on 21st prior to her death (30).

4.13 I understand the cause of death on the death certificate was:
1a) Bronchopneumonia
In my view a correct Death Certificate would have said:
1a) Bronchopneumonia
1b) Immobility following surgical repair of fractured neck of femur
1c) Fall
in the presence of 2 Severe dementia
There is no doubt that after people have been dying over a number of days, if a post mortem is performed, then secretions and changes of Bronchopneumonia are often found in the lungs as the very final agonal event. This allows clinicians to put the phrase "Bronchopneumonia" on the death certificate.

5. OPINION

5.1 Gladys Richards presents an example of a common, complex problem in geriatric medicine. A patient with one major progressive and end stage pathology (a dementing illness) develops a second pathology, has surgery, has a complication after that surgery, has more surgery and gradually deteriorates and dies.

5.2 However there were significant failings in the medical care provided to Gladys Richards, in particular:

- The failure to undertake a clinical examination, or to record it if it was undertaken on admission to the Gosport War Memorial Hospital.
- The PRN prescription of strong opioid analgesic on admission to the Gosport War Memorial Hospital without any explanation.
- The use of strong opioid analgesia on the 11th, 12th and 13th of August without any explanation. A decision that might have contributed to her hip dislocation.
- The failure to write up milder analgesic PRN on first admission to the Gosport War Memorial Hospital.
- The possible evidence that Mrs Richards was only reviewed medically after receiving further doses on Oramorphine on her readmission to the Gosport War Memorial Hospital on the 17th August.
- The failure to ask for specialist advice as to the cause of the continuing pain after the re-operation and second admission to the Gosport War Memorial Hospital.

5.3 There were deficiencies in the use of the drug chart at the Gosport War Memorial Hospital, in particular:

- The prescription of a large range of PRN Diamorphine on the PRN side of the drug chart.
- The "PRN" Oramorphine on the 'Regular' side of the drug chart, which is never given or crossed off.
- The prescription of a large range of a controlled drug (Diamorphine) on the regular side of the drug chart.
- The failure to write dosages of controlled drugs in words and figures as well as total dosages to be given.

6. EXPERTS' DECLARATION

1. I understand that my overriding duty is to the court, both in preparing reports and in giving oral evidence. I have complied and will continue to comply with that duty.
2. I have set out in my report what I understand from those instructing me to be the questions in respect of which my opinion as an expert are required.
3. I have done my best, in preparing this report, to be accurate and complete. I have mentioned all matters, which I regard as relevant to the opinions I have expressed. All of the matters on which I have expressed an opinion lie within my field of expertise.
4. I have drawn to the attention of the court all matters, of which I am aware, which might adversely affect my opinion.
5. Wherever I have no personal knowledge, I have indicated the source of factual information.
6. I have not included anything in this report, which has been suggested to me by anyone, including the lawyers instructing me, without forming my own independent view of the matter.
7. Where, in my view, there is a range of reasonable opinion, I have indicated the extent of that range in the report.
8. At the time of signing the report I consider it to be complete and accurate. I will notify those instructing me if, for any reason, I subsequently consider that the report requires any correction or qualification.
9. I understand that this report will be the evidence that I will give under oath, subject to any correction or qualification I may make before swearing to its veracity.
10. I have attached to this report a statement setting out the substance of all facts and instructions given to me which are material to the opinions expressed in this report or upon which those opinions are based.

7. STATEMENT OF TRUTH

I confirm that insofar as the facts stated in my report are within my own knowledge I have made clear which they are and I believe them to be true, and the opinions I have expressed represent my true and complete professional opinion.

Signature: _____ Date: _____

CURRICULUM VITAE

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EDUCATION	Leighton Park School, Reading, Berks.	1969-1973
	St John's College, Cambridge University.	1974-1977
	St Thomas' Hospital, London SE1	1977-1980

DEGREES AND QUALIFICATIONS

BA, Cambridge University	1977
(Upper Second in Medical Sciences)	
MB BChir, Cambridge University	1980
MA, Cambridge University	1981
MRCP (UK)	1983
Accreditation in General (internal) Medicine and Geriatric Medicine	1989
FRCP	1994
MBA (Distinction) University of Hull.	1997
KSS QESP part 1 2001. part 2	2009
NHS/INSEAD Clinical strategists program	2003
BAMM Fellow Awarded	2007
FAcadMed	2009

SPECIALIST SOCIETIES

British Geriatrics Society
British Society of Gastroenterology
British Association of Medical Managers
Association for the Study of Medical Education
Academy of Medical Educators

PRESENT POST

Consultant Physician (Geriatric Medicine) 1987-present.
Queen Marys Hospital, Sidcup, Kent.

Dean Director of Postgraduate Medical and Dental Education
Kent, Surrey and Sussex Deanery 2004-present

Honorary Chair in Medical Education.
Brighton and Sussex Medical School. 2005

PREVIOUS POSTS

Associate Dean.
London Deanery. 2004

Medical Director (part time) 1997-2003
Queen Marys Hospital

Operations Manager (part time) 1996-1997
Queen Marys Hospital, Sidcup, Kent

Senior Registrar in General and Geriatric Medicine
Guy's Hospital London and St Helen's Hospital
Hastings. 1985-1987

Registrar in General Medicine and Gastroenterology
St Thomas' Hospital, London. 1984-1985

Registrar in General Medicine	
Medway Hospital, Gillingham, Kent	1983-1984
SHO rotation in General Medicine	
Kent & Canterbury Hospital, Canterbury	1982-1983
SHO in General Medicine	
Kent & Sussex Hospital, Tunbridge Wells	1981-1982
House Physician, St Thomas' Hospital	1981
House Surgeon, St Mary's Portsmouth	1980

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