

OPERATION ROCHESTER

Investigation into the deaths of elderly patients at Gosport War Memorial Hospital

BRIEFING DOCUMENT

BACKGROUND

The Gosport War Memorial Hospital (GWMH) is a community hospital which is managed by the Portsmouth Health Care (NHS) Trust. It is operated on a day-to-day basis by nursing and support staff, employed by the Trust. Clinical expertise is provided by way of visiting general practitioners and clinical assistants, consultant cover is provided in the same way.

Elderly patients are usually admitted to GWMH through referrals from local hospitals or general practitioners for palliative, rehabilitative or respite care.

Doctor Jane BARTON is a registered Medical Practitioner who, in 1988, took up a part-time position at GWMH as Clinical Assistant in Elderly Medicine. She retired from that position in 2000, but continues to work as a General Practitioner in private practice in Gosport.

Dr. Anthea LORD is a Consultant Physician within the Department of Elderly Medicine of Portsmouth Health Care (NHS) Trust and she is responsible for patients at GWMH.

POLICE INVESTIGATIONS

Operation ROCHESTER is an investigation by Hampshire Police Major Crime Investigation Team into the deaths of a large number of elderly patients at GWMH. It is alleged that elderly patients who were admitted to the GWMH from as far back as 1989 for rehabilitative or respite care, were inappropriately administered Diamorphine by use of syringe drivers, resulting in their deaths.

Most of the allegations involve a particular General Practitioner, Doctor Jane BARTON. Death certificates of patients who died at the GWMH between 1995 and 2000 total 954, of which 456 were certified by Doctor Jane BARTON.

This matter has been investigated by Hampshire Police on three separate occasions.

First Police Investigation

Hampshire Police investigations commenced in 1998 following the death of Gladys RICHARDS, aged 91 years.

Mrs. Richards died at the GWMH on Code A whilst recovering from a surgical operation carried out at the nearby Royal Haslar Hospital to address a broken neck of femur on her right side (hip replacement).

Following the death of Mrs. Richards, two of her daughters, Mrs. MACKENZIE and Mrs. LACK complained to the Hampshire Police about the treatment that had been given to their mother at the GWMH. Mrs. MACKENZIE contacted Gosport police on 27th September, 1998 and alleged that her mother had been unlawfully killed.

Officers from Gosport C.I.D. carried out an investigation and in due course, a file was submitted to the Crown Prosecution Service.

In March 1999 the Reviewing CPS Lawyer gave the opinion that on the evidence available, he did not consider a criminal prosecution was justified.

On hearing of this decision, Mrs. MACKENZIE expressed her dissatisfaction with the quality of the police investigation and made a formal complaint against the officers involved.

The complaint made by Mrs. MACKENZIE was upheld and a review of the police investigation was carried out.

Second Police Investigation

Detective Chief Inspector Ray BURT was appointed to re-investigate the case of Gladys RICHARDS. A team of detectives from the Major Crime Investigation Team (Eastern) commenced the re-investigation on Monday 17th April, 2000. A lengthy re-investigation was conducted into the death of Gladys RICHARDS. During the investigation, nursing and medical staff were interviewed, the majority of which were on tape and under caution. A list of staff interviewed is attached (**Appendix A**).

Professor Brian LIVESLEY, who is an elected member of the Academy of Experts, provided expert medical opinion. Professor LIVESLEY provided a report dated 9th November, 2000 of his findings in the case of Gladys RICHARDS. Professor LIVESLEY made the following conclusions:

- "Doctor Jane BARTON prescribed the drugs Diamorphine, Haloperidol, Midazolam and Hyoscine for Mrs. Gladys RICHARDS in a manner as to cause her death."
- "Mr. Philip James BEED, Ms. Margaret COUCHMAN and Ms. Christine JOICE were also knowingly responsible for the administration of these drugs."
- "As a result of being given these drugs, Mrs. RICHARDS was unlawfully killed."

Professor LIVESLEY provided a second report dated 10th July, 2001 during which he added:

• "It is my opinion that as a result of being given these drugs, Mrs. Richards death occurred earlier than it would have done from natural causes."

As a result of Professor LIVESLEY's report dated 9th September, 2000, a meeting took place on 19th June, 2001 between senior police officers, the CPS caseworker Mr. Paul CLOSE, Treasury Counsel and Professor LIVESLEY. During that meeting, Treasury Counsel came to the view that Professor LIVESLEY's report on the medical aspects of the case, and his assertions that Mrs. RICHARDS had been unlawfully killed were flawed in respect of his analysis of the law. He was not entirely clear of the legal ingredients of gross negligence/manslaughter.

In August, 2001 the Crown Prosecution Service advised that their was insufficient evidence to provide a realistic prospect of a conviction against any person.

Local media coverage of the case of Mrs. Gladys RICHARDS resulted in other families raising concerns about the circumstances of their relatives' deaths at the GWMH. As a result of this, Detective Superintendent John JAMES selected, at random, four more cases for review. The cases he selected were those of:

Arthur Brian CUNNINGHAM
Alice WILKIE

Robert WILSON

Eva PAGE

D/Supt. JAMES sought the expert opinions of a further two Medical Professors. These were Professor FORD and Professor MUNDY. D/Supt JAMES provided each of the Professors with copies of the medical records of the above four cases in addition to the medical records of Gladys RICHARDS.

Each Professor provided a report of their findings, and a brief summary from each is as follows:

Professor FORD - Report dated 12th December, 2001

Gladys RICHARDS

"There was inappropriate prescribing of opiates and sedative drugs by Doctor BARTON . . . In my opinion, it is likely that the administration of the drugs hastened her death."

Arthur CUNNINGHAM

"The initial prescription of subcutaneous Diamorphine, Midazolam and Hyoscine by Doctor BARTON was in my view reckless . . . I consider the doses of these drugs were inappropriate and most likely contributed to his death."

Alice WILKIE

"In my opinion the prescription of Diamorphine and Midazolam was inappropriate which may have hastened her death."

Robert WILSON

"In my opinion he was inappropriately treated with high doses of opiate and sedative drugs which may have contributed to his death."

Eva PAGE

"I cannot identify a reason for the prescription of Diamorphine, Midazolam and Hyoscine by Doctor BARTON... In my view this was an inappropriate, potentially hazardous prescription."

Having reviewed the five cases, Professor FORD considered that they "raise serious concerns about the general management of older people admitted for rehabilitation . . . and that the level of skills of nursing and non-consultant medical staff, particularly Doctor BARTON, were not adequate at the time these patients were admitted."

Professor MUNDY - Report dated 18^{the} October, 2001

Professor MUNDY did not report on the case of Gladys RICHARDS.

Arthur CUNNINGHAM

"In my view, morphine was started prematurely . . . the switch to a syringe driver was made without any clear reason . . . the dose was increased without any clear indication as to why."

Alice WILKIE

"In my view, the dose of Diamorphine which was prescribed initially was excessive . . . there is no evidence that the dose was reviewed prior to her death."

Robert WILSON

"Simple analgesia was prescribed but never given . . . no other analgesia was tried prior to starting morphine."

Eva PAGE

"There was no documentation of any pain experienced by the patient . . . she was started on opiate analgesia in my view inappropriately."

Professor MUNDY concludes that in his opinion "... the use of Diamorphine as described in these four cases suggests that the subscriber did not comply with standard practice."

The reports from Professor FORD and Professor MUNDY were reviewed and a decision was taken not to forward them to the CPS as they were all of a familiar nature to the RICHARDS case and would therefore attract a similar reply. A decision was then made that there would be no further police investigations at that time.

Copies of the expert witness reports of Professor FORD and Professor MUNDY were forwarded to the General Medical Council, the Nursing and Midwifery Council and the Commission for Health Improvement for appropriate action.

Intervening Developments between Second and Third Investigations

On 22nd October, 2001 the Commission for Health Improvement (CHI) launched an investigation into the management, provision and quality of health care for which Portsmouth Health Care (NHS) Trust was responsible in GWMH. During the investigation 59 staff from GWMH were interviewed (staff details **Appendix B**).

A report of the findings of the CHI investigation was published in May 2002. The report concluded that a number of factors (detailed in the report) contributed to a failure of the Trust systems to ensure good quality patient care. However, the Trust now has adequate policies and guidelines in place that are being adhered to, governing the prescription and administration of pain relieving medicines to older patients.

Following the CHI Report, the Chief Medical Officer, Sir Liam DONALDSON, commissioned Professor Richard BAKER to conduct a statistical analysis of the mortality rates at GWMH, including an audit/review of the use of opiate drugs.

On Monday 16th September, 2002 staff at GWMH were assembled in order to be informed of the intended audit at the hospital by Professor BAKER. Immediately after the meeting concluded, nurse Anita TUBBRITT, who had been employed at GWMH since the late 1980s, handed over to the hospital management a bundle of documents. These documents were copies of memos, letters and minutes all relating to the concerns of nursing staff which were raised at a series of meetings held in 1991 and early 1992 about the increased mortality rate of elderly patients at the hospital, the sudden introduction of syringe drivers and their use by untrained staff and the use of Diamorphine unnecessarily or without consideration of the sliding scale of analgesia (Wessex Protocol). Concerns raised by nursing staff in relation to the prescribed Diamorphine involved Doctor Jane BARTON.

As a result of the disclosure of the 1991 documents supplied by Anita TUBBRITT, two NHS Chief Executives, Ian PIPER and Tony HORN, who were in management positions in 1991 were given immediate temporary redeployment. The existence of the documents was reported to the police and a meeting of senior police and NHS staff was subsequently held on 19th September, 2002 at Hampshire Police Support Headquarters. The following decisions were made at that meeting:

Further police enquiries were necessary in light of the new information and an enquiry team would be assembled and based at Hulse Road, Southampton. The enquiry team would:

- Examine the new documentation and investigate the events of 1991;
- Review existing evidence and new material in order to identify any additional viable lines of enquiry;
- Submit the new material to the experts and subsequently to CPS;
- Examine individual and corporate liability.

It was decided that a press release was necessary, which would include a free phone telephone number for concerned relatives to contact police. It was also decided that a Police Family Liaisons Officer needed to be appointed.

Third Police Investigation

On 23rd September, 2002 Hampshire Major Crime Investigation Team commenced enquiries. To date, relatives of 62 elderly patients have contacted police with regards to the deaths of the patients at GWMH. A number of these relatives are part of a family group being represented by a firm of solicitors, namely ALEXANDER HARRIS of Manchester. Others contacted police through an NHS direct free phone number or directly, as a result of publicity. Code A has been appointed the Family Contact Officer to co-ordinate contact with families.

The current police investigation is being conducted in stages, as follows:

Stage One

Enquiries into the documents and events of 1991. (Now completed) In summary, the events of 1991 were as follows:

- A number of night-nursing staff at GWMH had concerns as earlier stated and held a private meeting to discuss the issues. They were conscious of an on-going case within the NHS of GRAHAM PINK, a Charge Nurse working in the care of elderly patients in Stockport, who was dismissed for "whistle blowing".
- It was decided that three of the nurses would approach the hospital management and raise their concerns. The nurses raised their concerns with the Patient Care Manager, Isabel EVANS.
- A series of meetings took place between management, medical and nursing staff.
- A final meeting took place in which the nursing staff were informed by both the hospital management and medical staff, that the problems raised were due to a lack of

understanding by nursing staff concerning the use of Diamorphine. In addition, there was also a training issue in relation to syringe drivers.

• Although the nursing staff were not entirely happy with the outcome of the meetings, they felt that they had done everything they could in raising the issues, but in light of the PINK case, felt there was no more they could do, apart from retaining the documentation.

Stage Two

Obtaining further expert medical opinions.

This stage has been commenced with the appointment of Professor Robert FORREST of the Sheffield Medico-Legal Centre. Professor FORREST has agreed to lead a team of medical experts in elderly patient care. Currently, medical records of the initial 62 patients are being copied onto computer discs. A seminar/presentation is in the process of being organized, at which the police investigation will be outlined to the team of medical experts. Copies of the discs will be provided to each expert in order that their examination of the medical records may commence.

Subject to the findings of the medical experts, consideration will be given to further investigations (Stage Three), and the possible preparation of a file of evidence for submission to the CPS.

OTHER CONSIDERATIONS

Based upon the reports of Professors' LIVESLEY, FORD and MUNDAY in relation to the RICHARDS case, the General Medical Council (GMC) intend to take disciplinary action against Doctor Jane BARTON. Following a meeting with the police, the GMC has agreed to put a stay on their disciplinary hearing until the conclusion of the police investigation.

Hampshire and Isle of Wight Strategic Health Authority commissioned an internal NHS Management Investigation in relation to discipline matters at GWMH.

The CHI has been instructed by the Secretary of State for Health to produce a second report in relation to issues at the GWMH between 1988 and 1998.

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Both the Strategic Health Authority and the CHI investigations would involve enquiries and

interviewing of staff at the GWMH. Concerns by the police about the adverse effect these enquiries

may have on the current police investigation have been raised with the Chief Medical Officer, Sir Liam

DONALDSON.

As a result of the issues raised by the police, the Chief Medical Officer has agreed to suspend the

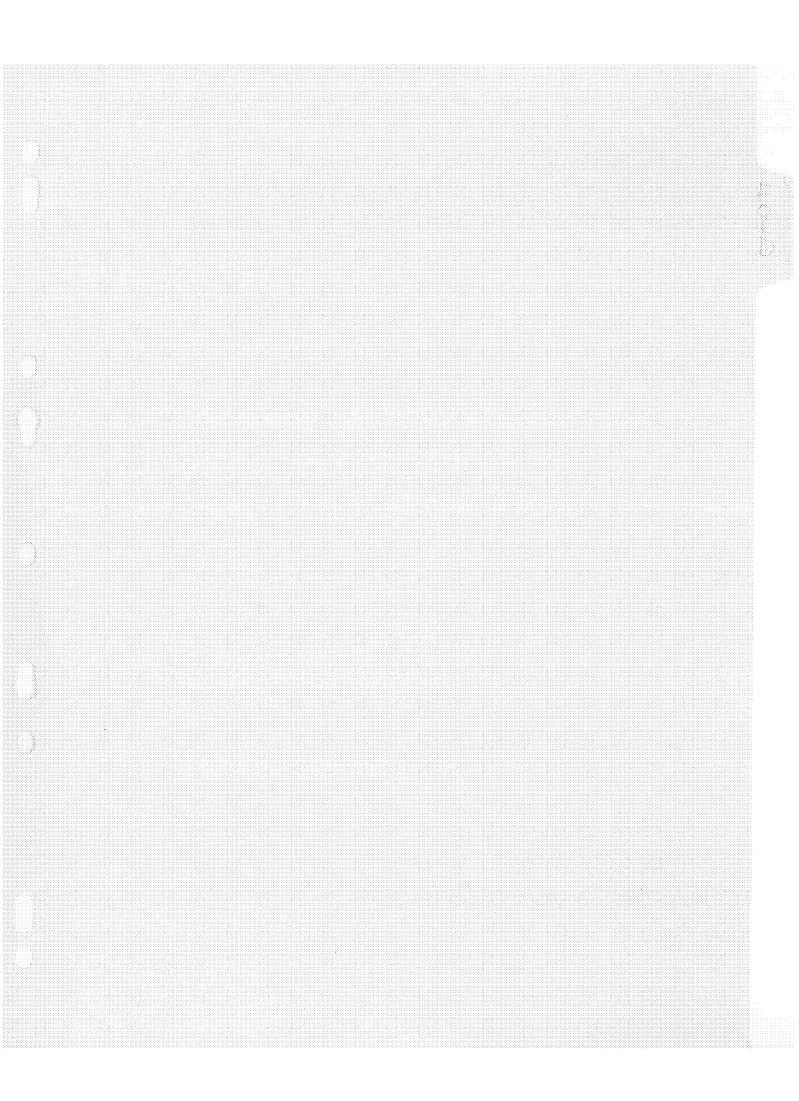
investigations by the Strategic Health Authority and the CHI until after the conclusion of the police

investigation.

Report Dated: 27th January, 2003

Owen J. Kenny

Detective Sergeant



MEDICO-LEGAL REPORT

Re:

Gladys Mabel RICHARDS

Arthur "Brian" CUNNING HAM

Alice WILKE Robert WILSON

Eva PAGE

Prepared by:

Professor G A Ford, MA, FRCP

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Professor of Pharmacology of Old Age, University of

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For:

Hampshire Constabulary

Date:

12th December 2001

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Introduction and Remit of the Report

8.1

Code A

- I have been asked by Detective Superintendent John James of Hampshire Constabulary to examine the clinical notes of five patients (Gladys Mabel Richards, Arthur "Brian" Cunningham, Alice Wilkie, Robert Wilson, Eva Page) treated at the Gosport War Memorial Hospital and to apply my professional judgement to the following:
- The gamut of patient management and clinical practices exercised at the hospital
- Articulation of the leadership, roles, responsibilities and communication in respect of the clinicians involved
- The accuracy of diagnosis and prognosis including risk assessments
- An evaluation of drugs prescribed and the administration regimes
- The quality and sufficiency of the medical records
- The appropriateness and justification of the decisions that were made
- Comment on the recorded causes of death
- Articulate the duty of care issues and highlight any failures
- 1.3 I have prepared individual reports on each case and an additional report commenting on general aspects of care at Gosport War Hospital from a consideration of all five cases.
- 1.4 I have been provided with the following documents by Hampshire Constabulary, which I have reviewed in preparing this report:
- Comment on the recorded causes of death
- Letter Code A dated 15th August 2001
- Terms of Reference document
- Hospital Medical Records of Gladys Richards, Brian Cunningham, Alice Wilkie, Robert Wilson and Eva Page
- Witness statements by Leslie France Lack, and Gillian MacKenzie
- Report of Professor Brian Livesley
- Transcripts of police interviews with Gosport War Memorial staff Dr Barton, Mr Beed, Ms Couchman, Ms Joice

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- Transcript of police interviews with Royal Hospital Haslar staff Dr Reid and Flt.
 Lt. Edmondson
- Transcript of interviews with patient transfer staff Mr Warren and Mr Tanner
- Transcript of police interviews with or statements from following medical and nursing staff: Dr Lord, LM Baldacchino, M Berry, JM Brewer, J Cook, E Dalton, W Edgar, A Fletcher, J Florio and A Funnell.

Gladys Mabel RICHARDS

Course of Events

- 2.1 Gladys Richards was 91 years old when admitted as an emergency via the Accident & Emergency Department to Haslar Hospital on 29Th July 1998. She had fallen onto her right hip and developed pain. At this time she lived in a nursing home and was diagnosed as having dementia. She had experienced a number of falls in the previous 6 months and the admission notes comments "quality of life has ↓↓ markedly last 6/12". She was found to have a fracture of the right neck of femur. An entry in the medical notes by Surgeon Commander Malcom Pott, Consultant orthopaedic surgeon dated 30 July 1998 states 'After discussion with the patient's daughters in the event of this patient having a cardiac arrest she is NOT for cardiopulmonary resuscitation. However she is to be kept pain free, hydrated and nourished.' Surgery (right hemiarthroplasty) was performed on 30 July 1998.
- 2.2 On 3rd August she was referred for a geriatric opinion and seen by Dr Reid, Consultant Physician in Geriatrics on 3rd August 1998. In his letter dated 5th August 1998 he notes she had been on treatment with haloperidol and trazadone and that her daughters thought she had been 'knocked off' by this medication for months, and had not spoken to then for 6-7 months. Her mobility had deteriorated. Her daughters commented to Dr Reid that she had spoken to them and had been brighter mentally since the trazadone had been omitted following admission. Dr Reid found Mrs Richards to be confused but pleasant and cooperative, unable to actively lift her right leg from the bed but appeared to have little discomfort on passive movement of the right hip. He commented 'I understand she has been sitting out in a chair and I think that despite her dementia, she should be afforded the opportunity to try to re-mobilise her. He arranged for her transfer to Gosport War Memorial Hospital.
- 2.3 Following Dr Reid's entry in the notes on 3rd August two further entries are made in the medical notes by the on call house officer (Dr Coales?) on 8th August 1998. Dr Coales was asked to see Mrs Richards who was agitated on the ward. She had been given 2mg haloperidol and was asleep when first seen at 0045h. At 02130 hr a further entry records Mrs Richards was 'noisy and disturbing other patients n ward. Unable to reason with patient. Prescribed 25mg thioridazine. A transfer letter for Sergeant Curran, staff nurse to the Sister in Charge dated 10th August 1998 describes Mrs Richards status immediately prior to transfer and notes 'Is now fully weight bearing, walking with the aid of two nurses and a zimmer frame. Gladys needs total care with washing and dressing eating and drinking. Gladys is continent, when she becomes fidgety and agitated it means she wants the toilet. Occasionally incontinent at night, but usually wakes.
- 2.4 On 11th August 1998 Mrs Richards was transferred to Daedalus ward. Dr Barton writes in the medical notes "Impression frail demented lady, 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". The summary admitting nursing notes record "now fully weight bearing and walking with the aid of two nurses and a Zimmer frame". On 12th August the nursing notes record "Haloperidol given at 2330 as woke from sleep. Very agitated, shaking and crying. Didn't settle for more than a few minutes at a

- time. Did not seem to be in pain". On 13th August nursing notes record "found on floor at 1330h. Checked for injury none apparent at time. Hoisted into safer chair. 1930 pain Rt hip internally rotated, Dr Brigg contacted advised Xray am and analgesia during the night. Inappropriate to transfer for Xray this pm."
- 2.5 On 14th August 1998 Dr Barton wrote 'sedation/pain relief has been a problem. Screaming not controlled by haloperidol 1g? but very sensitive to Oramorph. Fell out of chair last night. R hip shorter and internally rotated, Daughter nurse and not happy. Plan Xray. Is this lady well enough for another surgical procedure?" A further entry the same day states "Dear Cdr Spalding, further to our telephone conversation thank you for seeing this unfortunate lady who slipped from her chair and appears to have dislocated her R hip. Hemiarthroplasty was done on 30-8-98. I am sending Xrays. She has had 2.5ml of 10mg/5ml oramoroph at midday. Many thanks".
- 2.6 Following readmission to Haslar hospital Mrs Richards underwent manipulation of R hip under iv sedation (2 mg midazolam) at 1400h. At 2215h the same day she was not responding to verbal stimulation but observations of blood pressure, pulse, respiration and temperature were all in the normal range. A further entry on 17th August by Dr Hamlin (House Officer) states "fit for discharge today (Gosport War Mem) To remain in straight knee splint for 4/52. For pillow between legs (abduction) at night." A transfer letter to the nurse in charge at Daedalus ward states "Thank you for taking Mrs Richards back under your care... was decided to pass an indwelling catheter which still remains in situ. She has been given a canvas knee immobilising splint to discourage any further dislocation and this must stay in situ for 4 weeks. When in bed it is advisable to encourage abduction by using pillows or abduction wedge. She can however mobilise fully weight bearing".
- 2.7 Nursing notes record on 17th August "1148h returned from R.N.Haslar patient very distressed appears to be in pain. No canvas under patient -transferred on sheet by crew." Later that day at 1305h "in pain and distress, agreed with daughter to give her mother Oramorph 2.5mg in 5ml". A further hip Xray was performed which demonstrated no fracture. Dr Barton writes on 17th August 1998 "readmission to Daedalus ward. Closed reduction under iv sedation. Remained unresponsive for some hours. Now appears peaceful. Can continue haloperidol, only for Oramorph if in severe pain. See daughter again" and on 18th August "still in great pain, nursing a problem, I suggest sc diamorphine/ haloperidol/midazolam. I will see daughters today. Please make comfortable". Nursing notes record "reviewed by Dr Barton for pain control via syringe driver". At 2000h "patient remained peaceful and sleeping. Reacted to pain when being moved - this was pain in both legs". On 19th August the nursing notes record "Mrs Richards comfortable" and in a separate entry "apparently pain free". There are no nursing entries I can find on 20th August. I can find no entries in the nursing notes describing fluid or food intake following admission on 17th August.
- 2.8 The next entry in the medical notes is on 21st August by Dr Barton "much more peaceful. Needs hyoscine for rattly chest". The nursing notes record "patient's overall condition deteriorating. Medication keeping her comfortable". A staff nurse records Mrs Richards's death in the notes at 2120h later that day. The cause of death was recorded as bronchopneumonia.

2.9 Medication charts record the following administration of opiate, analgesic and sedative drugs during Mrs Richards's first admission to Haslar Hospital.

29 July 2000h Trazadone 100mg (then discontinued)

29 July to 11th August. Haloperidol 1mg twice daily

30 July 0230h Morphine iv 2.5mg

31 July0150h morphine iv 2.5mg

1905h morphine iv 2.5 mg

1 Aug 1920h morphine iv 2.5mg

2 Aug 0720h morphine iv 2.5mg

Cocodamol

two tablets as required taken on 16 occasions at varying times

between 1-

9th August

2.10 Medication charts record the following administration of opiate, analgesic and sedative drugs during Mrs Richards second admission to Haslar Hospital

14 Aug 1410h midazolam 2mg iv

15 Aug 0325h cocodamol two tablets orally

16 Aug 0410h haloperidol 2mg orally

0800h haloperidol 1mg orally

1800h haloperidol 1mg orally

2310h haloperidol 2mg orally !7 Aug 0800h haloperidol 1mg orally

2.11 Medication charts record the following administration of opiate and sedative drugs on Daedalus ward:

11 Aug	1115h 5mg/5ml Oramorph
	1145h 10 mg Oramorph
	1800h 1 mg haloperidol
12 Aug	0615h 10 mg Oramorph
	haloperidol
13 Aug	2050h 10mg Oramorph
14 Aug	1150h 10mg Oramorph
17 Aug	1300h 5mg Oramorph
	? 5 mg Oramorph
	1645h 5mg Oramorph
	2030h 10mg Oramorph
18 Aug	0230h 10mg Oramorph
	? 10mg Oramorph
	1145h diamorphine 40mg/24hr, haloperidol 5mg/24hr
	midazolam 20mg/24hrby
19 Aug	1120h diamorphine 40mg/24hr, haloperidol 5mg/24hr
	midazolam 20mg/24hr, hyoscine 400microg/24hr
20 Aug	1045h diamorphine 40mg/24hr, haloperidol 5mg/24hr
	midazolam 20mg/24hr, hyoscine 400microg/24hr
21 Aug	1155h diamorphine 40mg/24h, haloperidol 5mg/24hr
	midazolam 20mg/24hr, hyoscine 400microg/24hr

Opinion on patient management

Leadership, roles, responsibilities and communication in respect of the clinicians involved

- 2.12 Primary responsibility for the medical care of Mrs Richards during her two admissions to Gosport Hospital lay with Dr Lord, as the consultant responsible for his care. My understanding is that day-to-day medical care was delegated to the clinical assistant Dr Barton and during out of hours period the on call doctor based at the Queen Alexander Hospital (statement of Dr Lord in interview with Code A and Code A Primary responsibility for the medical care of Mrs Richards during her two admissions to Queen Alexandra Hospital lay with Surgeon Commander Scott, Consultant Orthopaedic Surgeon. Junior medical staff were responsible for day-to-day medical care of Mrs Richards whilst at Queen Alexandra Hospital. Ward nursing staff were responsible for assessing and monitoring Mrs Richards and informing medical staff of any significant deterioration.
- 2.13 Dr Reid, Consultant Geriatrician was responsible for assessing Mrs Richards and making recommendations concerning her future care following her orthopaedic surgery, and arranged transfer to Gosport Hospital for rehabilitation.

Accuracy of diagnosis and prognosis including risk assessments

- 2.14 The initial assessment by the orthopaedic team was in my opinion competent and the admitting medical team obtained a good history of her decline in the previous six months. Surgeon Commander Pott discussed management options with the family and a decision was made to proceed with surgery but for Mrs Richards to not undergo cardiopulmonary resuscitation if she sustained a cardiac arrest, with a clear decision to keep Mrs Richards pain free, hydrated and nourished. There are good reasons to offer surgery for a fractured neck of femur to very frail patients with dementia even when a high risk of peri-operative death or complications is present. This is because without surgery patients continue to be in pain, remain immobile and nearly invariably develop serious complications such as pneumonia and pressure sores, which are usually fatal. From the information I have seen I would, as a consultant physician/geriatrician recommended the initial management undertaken. I consider it good management that the trazadone as discontinued when the history from the daughters suggested this might have been responsible for decline in the recent past.
- 2.15 After Mrs Richards was stable a few days following surgery it was appropriate to refer her for a geriatric opinion, and Dr Reid rapidly provided this. Dr Reid's assessment was in my opinion thorough and competent. He identified the potential for her to benefit from rehabilitation. I would consider his decision to refer her for rehabilitation despite her dementia to be appropriate. An elderly care rehabilitation, rather than an acute orthopaedic ward is in general a preferable environment to undertake such rehabilitation. It is implicit in his decision to transfer her to Gosport War Memorial Hospital that she would receive rehabilitation there and not care on a continuing care ward without input from a rehabilitation team. Dr Lord in an interview with Code A and code and continuing care ward with 24 beds of which 8 beds were for slow stream stroke rehabilitation". Although Mrs Richards had a fractured neck of femur and not

- stroke as her primary problem requiring rehabilitation I would assume, in the light of Dr Reid's letter that she was transferred to one of the 8 slow stream rehabilitation beds on Daedalus ward.
- 2.16 The transfer letter from Sergeant Curran provides a clear description of Mrs Richards's status at the time of transfer. The observation that she was walking with the aid of two nurses and a zimmer frame, and the usual cause of agitation was when she needed to use the toilet are relevant to subsequent events following transfer to Gosport Hospital. The use of a Barthel Index score as a measure of disability is good practice and demonstrates that Mrs Richards was severely dependent at the time of her transfer to Gosport Hospital.
- 2.17 The initial entry by Dr Barton following Mrs Richards' transfer to Daedalus ward does not mention that she has been transferred for rehabilitation, and focuses on keeping her 'comfortable' despite recording that she is "not obviously in pain". The statement 'I am happy for nursing staff to confirm death" also suggests that Dr Barton's assessment was that Mrs Richards might die in the near future. Dr Barton in her statement to Code A and Code A confirms this when she states "I appreciated that there was a possibility that she might die sooner rather than later". Dr Barton refers to her admission as a "holding manoeuvre" and her statement suggests a much more negative view of the potential for rehabilitation. She does not describe any rehabilitation team or focus on the ward and suggests her transfer was necessary because she was not appropriate for an acute bed, rather than her being appropriate for rehabilitation- ".her condition was not appropriate for an acute bed.seen whether she would recover and mobilise after surgery. 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 clam environment away from the stresses of an acute ward". In my opinion this initial note entry and the statement by Dr Baron indicate a much less proactive view of rehabilitation, less appreciation than Dr Reid of the potential for Mrs Richards to recover to her previous level of functioning, and probably a failure to appreciate the potential benefits of appropriate multidisciplinary rehabilitation to Mrs Richards. This leads me to believe that Dr Barton's approach to Mrs Richards was in the context of considering her as a continuing care patient who was likely to die on the ward. It was not wrong or incorrect of Dr Barton to believe Mrs Richards might die on the ward, but I would consider her apparent failure to recognise Mrs Barton's rehabilitation needs may have led to
- 2.18 There are a number of explanations and contributory factors that may have led to Dr Barton possibly not recognising Mrs Richard's rehabilitation needs in addition to her nursing and analgesic needs. First she may have not clearly understood Dr Reid's assessment that she needed rehabilitation. In her statement Dr Barton states "Dr Reid was of the view that, despite her dementia, she should be given the opportunity to try to remobilise" which suggests Dr Barton may not have considered the necessity for Mrs Richards to receive Physiotherapy as a necessary part of her opportunity to remobilise. Second the ward had both continuing care and rehabilitation beds and these patients may require very different care. It is not uncommon for "slow stream" rehabilitation beds to be in the same ward as continuing care beds, but it does require much broader range of care to meet the medical and social needs of

subsequent sub-optimal care.

these patients. I would anticipate that some patients would move from the slow stream rehabilitation to continuing care category. Dr Lord describes the existence of fortnightly multidisciplinary ward case conference suggesting there was a structured team approach that would have made Dr Barton and nursing staff aware of rehabilitation needs of patients. In Mrs Richards's case no such case conference took place because she became too unwell in a short period. Third Dr Barton may not have received sufficient training or gained adequate experience of rehabilitation or geriatrics despite working under the supervision of Dr Lord. Dr Lord states that Dr Barton was "an experienced GP" who had rights of admission to a GP ward and that Dr Lord had admitted patients "under her care say for palliative care". Experience in palliative care may possibly have influenced her understanding and expectations of rehabilitating older patients.

- 2.19 The assessment of Mrs Richard's agitation the following day on 12th August was in my opinion sub-optimal. The nursing records state that she did not appear to be in pain. There is no entry from Dr Barton this day but in her statement she states which I have some difficulty in interpreting: "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 totalling 20mg over the first 24 hours and 10mg daily thereafter. This would be an appropriate level of pain relief after such a major orthopaedic procedure".
- 2.20 I am unable establish from the notes and Dr Barton's statement whether she saw Mrs Richards in pain after she wrote in the notes and then wrote up the opiate drugs later on the 11th August, or if she wrote up these drugs after seeing her when she was not in pain, because she considered she might develop pain and agitation. In either case there is no evidence that the previous information provided by Sergeant Curran that Mrs Richards usually required the toilet when she was agitated was considered by Dr Barton. Screaming is a well-described behavioural disturbance in dementia (Dr Barton was clearly aware of this), which can be due to pain but is often not. In some cases it is not possible to identify a clear precipitating cause although a move to a new ward could precipitate such a behavioural disturbance. I would consider the assumption by Dr Barton that Mrs Richards screaming was due to pain was not supported by her own recorded observations. There is no evidence from the notes that Dr Barton examined Mrs Richards in the first two days to find any evidence on clinical examination that pain from her hip was the cause of her screaming. If the screaming had been worse on weight bearing or movement of the hip this would have provided supportive evidence that her screaming was due to hip pain. Staff Nurse Jennifer Brewer in her interview with Code A and Code A Code A states that the nursing staff had considered the need for toileting and other potential causes of Mrs Richards screaming.

- 2.21 Mrs Richards pain following surgery had been controlled at Haslar hospital by intermittent doses of intravenous morphine and then intermittent doses of cocodamol (paracetamol and codeine phosphate). Dr Barton did not prescribe cocodamol or another mild or moderate analgesic to Mrs Richards to take on a prn basis when she was transferred. This makes me consider it probable that Dr Barton prescribed prn Oramorph, diamorphine, hyoscine and midazolam when she first saw Mrs Richards and she was not in pain. If this is the case it is highly unusual practice in a patient who has been transferred for rehabilitation. was not taking any regular or intermittent analgesics for 36 hours prior to transfer, and had last taken two tablets of cocodamol. In a rehabilitation or continuing care ward without resident medical staff I would consider it reasonable and usual practice to prescribe a mild or moderate analgesic to take on an as required basis in case further pain developed. In Mrs Richards's case a reasonable choice would have been cocodamol since she had been taking this a few days earlier without problems. I do not consider it was appropriate to administer intermittent doses of oramorph to Mrs Richards before first prescribing paracetamol, non-steroidal anti-inflammatory drugs or mild opiate. It is not appropriate to prescribe powerful opiate drugs as a first line treatment for pain not clearly due to a fracture or dislocation to a patient such as Mrs Richards 12 days following surgery. Dr Barton's statement that diamorphine and oramorph were appropriate analgesics at this stage following surgery when she had been pain free is incorrect and in my opinion would not be a view held by the vast majority of practising general practitioners and geriatricians.
- 2.22 The management of Mrs Richards when sustained a dislocation of her hip on 13th August was in my opinion sub-optimal. The hip dislocation most likely occurred following the fall from her chair at 1330h. The nursing notes suggest signs of a dislocation were noted at 1930h. If there was a delay in recognising the dislocation I would not consider this indicates poor care, as hip fractures and dislocations can be difficult to detect in patients who have dementia and communication difficulties. Mrs Richards suspected dislocation or fracture was discussed with the on-call doctor, Dr Briggs, who I would assume is a medical house officer. Given the concern about a fracture or dislocation I would judge it would have been preferable for her to b transferred to the orthopaedic ward that evening and be assessed by the orthopaedic team. I certainly consider the case should have been discussed with either the on call consultant geriatrician or the orthopaedic team. The benefits of transfer that evening in a patient where it was highly probable a fracture or dislocation were present would have been Mrs Richards could have received manipulation earlier the following morning and possibly that same evening, and that traction could have been applied even if reduction was not attempted.
- 2.23 Mrs Richards was found to have a dislocation of her right hip and this was manipulated under intravenous sedation the same day. Although she was initially unresponsive, most probably due to prolonged effects of the intravenous midazolam, 3 days later on 17th August she was mobilising and fully weight bearing and not requiring any analgesia. Although there are few medical note entries, the management at Haslar hospital during this period appears to be appropriate and competent. Shortly after transfer back to Daedalus ward Mrs Richards again became very distressed. The nursing notes indicate there was an incorrect transfer by the ambulance staff of Mrs Richards onto her bed.

Repeat dislocation of the right hip was reasonably suspected but not found on a repeat Xray. My impression is that this transfer may have precipitated hip or other musculoskeletal pain in Mrs Richards but that other causes of screaming were possible.

- 2.24 Intermittent doses of oral morphine were first administered to Mrs Richards, again without first determining whether less powerful analgesics would have been helpful. On 18th August Dr Barton suggested commencing subcutaneous diamorphine, haloperidol and midazolam. The diamorphine and midazolam had been prescribed 7 days earlier. An infusion of the three drugs was commenced later that morning and hyoscine was added on 19th August. Both Dr Barton's notes and the nursing notes indicate Mrs Richards was in pain, although it is not clear what they considered was the cause of the pain at this stage, having excluded a fracture or dislocation of the right hip. Dr Barton states in her prepared statement "... 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".
- 2.25 Although there are no clear descriptions of Mrs Richard's conscious level in the last few days, her level of alertness appears to have deteriorated once the subcutaneous infusion of diamorphine, haloperidol and midazolam was commenced. It also seems that she was not offered fluids or food and intravenous or subcutaneous fluids were not considered as an alternative. My interpretation is that this was most probably because medical and nursing staff were of the opinion that Mrs Richards were dying and that provision of fluids or nutrition would not change this outcome. In her prepared statement Dr Barton states "As their mother was not eating or drinking or able to swallow, subcutaneous infusion of pain killers was the best way to control her pain." and "I was aware that Mrs Richards was not taking food or water by mouth". She then goes on to say "I believe I would have explained to the daughters that subcutaneous fluids were not appropriate".

Evaluation of drugs prescribed and the administration regimens

2.26 The decision to prescribe oral opiates and subcutaneous diamorphine to Mrs Richards initial admission to Daedalus ward was in my opinion inappropriate and placed Mrs Richards at significant risk of developing adverse effects of excessive sedation and respiratory depression. The prescription of oral paracetamol, mild opiates such as codeine or non-steroidal anti-inflammatory drugs such as ibuprofen, naproxen would have been appropriate oral and preferable with a better risk/benefit ratio. The prescription of subcutaneous diamorphine, haloperidol and midazolam infusions to be taken if required was inappropriate even if she was experiencing pain. Subcutaneous opiate infusions should be used only in patients whose pain is not controlled by oral analgesia and who cannot swallow oral opiates. The prescription by Dr Barton on 11th August of three sedative drugs by subcutaneous infusion was in my opinion reckless and inappropriate and placed Mrs Richards at serious risk of developing coma and respiratory depression had these been administered by the nursing staff. It is exceptionally unusual to prescribe subcutaneous infusion of these three drugs with powerful effects on conscious level and respiration to frail elderly patients with non-malignant conditions in a continuing care or slow stream rehabilitation ward and I have not personally used, seen or heard of this practice in other care of the elderly rehabilitation or continuing care wards. The

- prescription of three sedative drugs is potentially hazardous in any patient but particularly so in a frail older patient with dementia and would be expected to carry a high risk of producing respiratory depression or coma.
- 2.27 I consider the statement by Dr Barton "my use of midazolam in the dose of 20mg 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." Indicates poor knowledge of the indications for and appropriate use of midazolam administered by subcutaneous infusion to older people. Midazolam is primarily used for sedation and is not licensed for use as a muscle relaxant. Doses of benzodiazepine that produce significant muscle relaxation in general produce unacceptable depression of conscious level, and it is not usual practice amongst continuing care and rehabilitation wards to administer subcutaneous midazolam to assist moving patients.

Quality and sufficiency of the medical records

2.28 The medical and nursing records relating to Mrs Richards admissions to Daedalus ward are in my opinion not of an adequate standard. The medical notes fail to adequately account for the reasons why oramorph and then infusions of diamorphine and haloperidol were used. The nursing records do not adequately document hydration and nutritional needs of Mrs Richards during her admissions to Daedalus ward.

Appropriateness and justification of the decisions that were made

2.29 There are a number of decisions made in the care of Mrs Richards that I consider to be inappropriate. The initial management of her dislocated hip prosthesis was sub-optimal. The decision to prescribe oral morphine without first observing the response to milder opiate or other analgesic drugs was inappropriate. The decision to prescribe diamorphine, haloperidol and midazolam by subcutaneous infusion was, in my opinion, highly inappropriate.

Recorded cause of death

2.30 The recorded cause of death was bronchopneumonia. I understand that the cause of death was discussed with the coroner. A post mortem was not obtained and the recorded cause was certainly a possible cause of Mrs Richards's death. I am surprised the death certificate makes no mention of Mrs Richards's fractured neck of femur or her dementia. It is possible that Mrs Richards died from drug induced respiratory depression without bronchopneumonia present or from the combined effects of bronchopneumonia and drug-induced respiratory depression. Mrs Richards was at high risk of developing pneumonia because of the immobility that resulted following her transfer back to Daedalus ward even if she had not received sedative and opiate drugs. Bronchopneumonia can also occur as a secondary complication of opiate and sedative induced respiratory depression. In the absence of postmortem, radiological data (chest Xray) or recordings of Mr Cunningham's respiratory rate I would consider the recorded cause of death of bronchopneumonia was possible. However given the rapid decline in conscious level that preceded the development of respiratory symptoms (rattly chest) I would consider it more likely that Mrs Richards became unconscious because of the sedative and opiate drugs she received by subcutaneous infusion, that

these drugs caused respiratory depression and that Mrs Richards died from drug induced respiratory depression and/or without bronchopneumonia resulting from immobility or drug induced respiratory depression. There are no accurate records of Mrs Richards respiratory rate but with the doses used and her previous marked sedative response to intravenous midazolam it is highly probable that respiratory depression was present.

Duty of care issues

2.31 Medical and nursing staff on Daedalus ward had a duty of care to deliver medical and nursing care to attempt to monitor Mrs Richards and to document the effects of drugs prescribed. In my opinion this duty of care was not adequately met. The prescription of diamorphine, midazolam and haloperidol was extremely hazardous and Mrs Richards was inadequately monitored. The duty of care of the medical and nursing staff to meet Mrs Richard's hydration and nutritional needs was also in my opinion probably not met.

Summary

2.32 Gladys Richards was a frail older lady with dementia who sustained a fractured neck of femur, successfully surgically treated with a hemiarthroplasty, and then complicated by dislocation. During her two admissions to Daedalus ward there was inappropriate prescribing of opiates and sedative drugs by Dr Baron. These drugs in combination are highly likely to have produced respiratory depression and/or the development of bronchopneumonia that led to her death. In my opinion it is likely the administration of the drugs hastened her death. There is some evidence that Mrs Richards was in pain during the three days prior to her heath and the administration of opiates can be justified on these grounds. However Mrs Richards was at high risk of developing pneumonia and it possible she would have died from pneumonia even if she had not been administered the subcutaneous sedative and opiate drugs.

Arthur "Brian" CUNNINGHAM

Course of Events

- Mr Cunningham was 79 years old when admitted to Dryad ward, Gosport Hospital under the care of Dr Lord. Dr Lord had assessed him on a number of occasions in the previous 4 years. A letter dated 2nd December 1994 from Dr Bell, Clinical Assistant, indicates Parkinson's disease had been diagnosed in the mid 1980s and that he was having difficulties walking at this time. In 1998 it was noted he had experienced visual hallucinations and had moved into Merlin Park Rest Home. His weight was 69Kg in August 1998. In July 1998 he was admitted under the care of Dr Banks, Consultant in Old Age Psychiatry to Mulberry Ward A and discharged after 6 weeks to Thalassa Nursing Home. He was assessed to have Parkinson's disease and dementia, depression and myelodysplasia. Dr Lord in a letter dated 1 September 1998 summarises her assessment of Mr Cunningham when she saw him on Mulberry Ward A on 27 August 1998 before he was discharged to Thalassa Nursing Home. At this time he required 1-2 people to transfer and was unable to wheel himself around in his wheelchair. She commented that more levodopa might be required but was concerned it would upset his mental state. She arranged to review him at the Dolphin Day Hospital.
- 3.2 On 21st September 1998 he was seen at the Dolphin Day Hospital by Dr Lord who recorded 'very frail, tablets found in mouth, offensive large necrotic sacral sore with thick black scar. PD - no worse. Diagnoses listed as sacral sore (in N/H), PD, old back injury, depression and element of dementia, diabetes mellitus -diet, catheterised for retention. Plan -stop codanthramer and metronidazole. looks fine. TCl Dyad today -aserbine for sacral ulcer - nurse on side - high protein diet - oramorph pm if pain. N/Home to keep bed open for next 3/52 at least. Pt informed of admission agrees. Inform N/Home Dr Banks and social worker. Analgesics prn.' He was admitted to Dyad ward. An entry by Dr Baron on 21 September states 'make comfortable, give adequate analgesia. Am happy for nursing staff to confirm death.' On 24th September Dr Lord has written 'remains unwell. Son has ??? again today and is aware of how unwell he is. sc analgesia is controlling pain just. I am happy for nursing staff to confirm death.' The next entry by Dr Brook is on 25th September 'remains very poorly. On syringe driver. For TLC'.
- 3.3 Medication charts record the following administration of opiate and sedative drugs:

21 Sep 1415h Oramorph 5mg

1800h Coproxamol two tablets

(subsequent regular doses not administered)

2015h Oramorph10mg

21 Sep 2310h Diamorphine 20mg/24hr, midazolam 20mg/24hr infusion sc

22 Sep 2020h Diamorphine 20 mg/24hr, midazolam 20 mg/24hr infusion sc

23 Sep 0925h Diamorphine 20mg/24hr, hyoscine 200microg/24hr midazolam 20 mg/24hr infusion sc

2000h Diamorphine 20mg/24hr, hyoscine 200microg/24hr midazolam 60mg/24hr infusion sc

24 Sep 1055h Diamorphine 20mg/24hr, hyoscine 800microg/24hr midazolam 80mg/24hr infusion sc

25 Sep 1015h Diamorphine 60mg/24hr, hyoscine 1200mg/24hr

midazolam 80mg/24hr infusion 26 Sep 1150h Diamorphine 80mg/24hr, hyoscine 1200mg/24hr midazolam 100mg/24hr infusion Sinemet 110 5 times/day was discontinued on 23rd September

- 3.4 The nursing notes relating to the admission to Dyad ward record on 21st Sept 'remained agitated until approx 2030h. Syringe driver commenced as requested (unclear who made this request) diamorphine 20mg, midazolam 20mg at 2300. Peaceful following". On 22nd Sep 'explained that a syringe driver contains diamorphine and midazolam was commenced yesterday evening for pain relief and to allay his anxiety following an episode where Arthur tried to wipe sputum on a nurse saying he had HIV and going to give it to her. He also tried to remove his catheter and empty the bag and removed his sacral dressing throwing it across the room. Finally he took off his covers and exposed himself.'
- 3.5 On 23rd Sep 'Has become chesty overnight to have hyoscine added to driver. Stepson contacted and informed of deterioration. Mr Farthing asked is this was due to the commencement of the syringe driver and informed that Mr Cunningham was on a small dosage which he needed.' A later entry 'now fully aware that Brian is dying and needs to be made comfortable. Became a little agitated at 2300h, syringe driver adjusted with effect. Seems in some discomfort when moved, driver boosted prior to position change' On 24th Sept 'report from night staff that Brian was in pain when attended to, also in pain with day staff especially his knees. Syringe driver renewed at 1055". On 25th Sept 'All care given this am. Driver recharged at 1015 -diamorphine 60mg, midazolam 80mg and hyoscine 1200mcg at a rate of 50mmols/hr. Peaceful night unchanged, still doesn't like being moved.' On 26th September 'condition appears to be deteriorating slowly'.
- 3.6 On 26th September staff nurse Tubbritt records death at 2315h. Cause of death was recorded on the death certificate as bronchopneumonia with contributory causes of Parkinson's disease and Sacral Ulcer.

Opinion on patient management

Leadership, roles, responsibilities and communication in respect of the clinicians involved

3.7 Primary responsibility for the medical care of Mr Cunningham during his last admission lay with Dr Lord, as the consultant responsible for his care. She saw Mr Cunningham 5 days before his death in the Dolphin Day Hospital, and 2 days before his death on Dyad ward. My understanding is that day-to-day medical care was the responsibility of the clinical assistant Dr Barton and during out of hours period the on call doctor based at the Queen Alexander Hospital. Ward nursing staff were responsible for assessing and monitoring Mr Cunningham and informing medical staff of any significant deterioration.

Accuracy of diagnosis and prognosis including risk assessments

3.8 Initial assessment by Dr Lord was comprehensive and appropriate with a clear management plan described. The nursing staff record Mr Cunningham was agitated following admission on 21st September. Dr Lord had prescribed prn (intermittent as required) oramorph for pain. Nursing staff made the decision to administer oramorph but there is no clear recording in the nursing notes that he

was in pain or the site of pain. The nursing entry on 22nd Sept indicates a syringe driver was commenced for 'pain relief and to allay anxiety. Again the site of pain is not states. My interpretation of the records is that the nursing staff considered his agitation was due to pain from his sacral ulcer. The medical and nursing teams view on the cause of Mr Cunningham's deterioration on 23rd September when he became 'chesty' are not explicitly stated, but would seem to have been thought to be due to bronchopneumonia since this was the cause of death later entered on the death certificate. The medical and nursing staff may not have considered the possibility that Mr Cunningham's respiratory symptoms and deterioration may have been due to opiate and benzodiazepine induced respiratory depression. The nursing staff filed to appreciate that the agitation Mr Cunningham experienced on 23rd Sept at 2300h may have been due to the midazolam and diamorphine. It was appropriate for nursing staff to discuss Mr Cunningham's condition with medical staff at this stage.

3.9 When Dr Lord reviewed Mr Cunningham on 24th September the notes imply that he was much worse that when she had seen him 3 days earlier. There is clear recording by Dr Lord that Mr Cunningham was in pain. The following day the diamorphine dose was increased three fold from 20mg/24hr to 60mg/24hr and the dose was further increased on 26th September to 80mg/24hr although the nursing and medical notes do not record the reason for this. The notes suggest that the nursing and medical staff may have failed to consider causes of agitation other than pain in Mr Cunningham or to recognise the adverse consequences of opiates and sedative drugs on respiratory function in frail older individuals.

Evaluation of drugs prescribed and the administration regimens

- 3.10 The prescription of oramorph to be taken 4 hourly as required by Mr Cunningham was reasonable if his pain was uncontrolled from cocodamol. I consider the decision by Dr Barton to prescribe and administer diamorphine and midazolam by subcutaneous infusion the same evening he was admitted was highly inappropriate, particularly when there was a clear instruction by Dr Lord that he should be prescribed intermittent (underlined instruction) doses of oramorph earlier in the day. I consider the undated prescription by Dr Baron of subcutaneous diamorphine 20-200mg/24hr prn, hyoscine 200-800microg/24hr and midazolam 20-80mg/24hr to be poor practice and potentially very hazardous. In my opinion it is poor management to initially commence both diamorphine and midazolam in a frail elderly underweight patient such as Mr Cunningham. The combination could result in profound respiratory depression and it would have been more appropriate to review the response to diamorphine alone before commencing midazolam, had it been appropriate to commence subcutaneous analgesia, which as I have stated before was not the case.
- 3.11 In my opinion it is doubtful the nursing and medical staff understood that when a syringe infusion pump rate is increased it takes an often appreciable effect of time before the maximum effect of the increased dose rate becomes evident. Typically the time period would be 5 drug half-lives. In the case of diamorphine this would be between 15 and 25 hours in an older frail individual.

Quality and sufficiency of the medical records

3.12 In my opinion the medical and nursing records are inadequate following Mr Cunningham's admission to Dryad ward. The initial assessment by Dr Lord on

21st September is in my opinion competent and appropriate. The medical notes following this are inadequate and do not explain why he was commenced on subcutaneous infusions of diamorphine and midazolam. The nursing notes are variable and at times inadequate.

Appropriateness and justification of the decisions that were made

- 3.13 An inappropriately high dose of diamorphine and midazolam was first prescribed. There was a failure to recognise or respond to drug induced problems. Inappropriate dose escalation of diamorphine and midazolam and poor assessment by Dr Lord. The assessment by Dr Lord on 21st September 1998 was thorough and competent and a clear plan of management was outlined. There is a clear note by Dr Lord that oramorph was to be given intermittently (PRN) for pain and not regularly. It is not clear from the medical and nursing notes why Mr Cunningham was not administered the regular cocodamol he was prescribed following the initial dose he received at 1800h following admission. It is good practice to provide regular oral analgesia, with paracetamol and a mild opiate, particularly when a patient has been already taking this medication and to use prn morphine for breakthrough pain. I consider the prescription by Dr Barton on admission of prn subcutaneous diamorphine 20-200mg/24hr prn, hyoscine 200-800microg/24hr and midazolam 20-80mg/24hr to be unjustified, poor practice and potentially very hazardous. It is particularly notable that only hours earlier Dr Lord had written that oramorph was to be given intermittently and this had been underlined in the medical notes. There is no clear justification in the notes for the commencement of subcutaneous diamorphine and midazolam on the evening following admission. If increased opiate analgesia was required increasing the oramorph dose and frequency could have provided this. I would judge it poor management to initially commence both diamorphine and midazolam. The combination could result in profound respiratory depression and it would have been more appropriate to review the response to diamorphine alone before commencing midazolam.
- 3.14 I am concerned by the initial note entry by Dr Barton on 21st September 1998 that she was happy for nursing staff to confirm death. There was no indication by Dr Lord that Mr Barton was expected to die, and Dr Barton does not list the reason she would have cause to consider Mr Cunningham would die within the next 24 hours before he was reviewed the following day by medical staff. In my opinion it is of concern that the nursing notes suggest the diamorphine and midazolam infusions were commenced because of Mr Cunningham's behaviour recorded in the nursing entry on 22nd September.
- 3.15 Hyoscine was commenced on 23rd September after Mr Cunningham had become 'chesty' overnight. I consider it very poor practice that there is no record of Mr Cunningham being examined by a doctor following admission on 21st September, and a decision to treat this symptomatically with hyoscine appears to have been made by the medical staff. At this stage Mr Cunningham's respiratory signs are likely to have been due to bronchopneumonia or respiratory depression resulting in depressed clearance of bronchial secretions. A medical assessment was very necessary at this stage to diagnose the cause of symptoms and to consider treatment with antibiotics or reduction in the dose of diamorphine and midazolam.

- 3.16 Again I consider it very poor practice that the midazolam was increased from 20mg/24hr to 60mg/24 hr at 2000h on 23rd September. There is no entry in the medical notes to explain this dose increase. The decision to triple the midazolam dose appears to have been made by a member of nursing staff as the nursing notes record "agitated at 2300h, syringe driver boosted with effect".
- 3.17 A medical assessment should have been obtained before the decision to increase the midazolam dose was made. At the very least Mr Cunningham's problems should have been discussed with on call medical staff. Mr Cunningham's agitation may have been due to pain, where increasing analgesia would have been appropriate, or hypoxia (lack of oxygen). If Mr Cunningham's agitation was due to hypoxia a number of interventions may have been indicated. Reducing the diamorphine and midazolam dose would have been appropriate if hypoxia was due to respiratory depression. Commencement of oxygen therapy and possibly antibiotics would have been appropriate if hypoxia was due to pneumonia. Reducing the dose diamorphine or midazolam would have been indicated if hypoxia was due to drug-induced respiratory depression. The decision to increase the midazolam dose was not appropriately made by the ward nursing staff without discussion with medical staff.
- 3.18 When Mr Cunningham was reviewed by Dr Lord on 24th September he was very unwell but there is not a clear description of his respiratory status or whether he had signs of pneumonia. At this stage Dr Lord notes Mr Cunningham is in pain, but does not state the site of his pain. It is not clear to me whether the subsequent alteration in infusion rate of diamorphine, hyoscine and midazolam was discussed with and sanctioned by Dr Lord or Dr Barton. I consider the increase in midazolam from 60mg/24 hr to 80mg/24 hr was inappropriate as a response to the observation that Mr Cunningham was in pain. It would have been more appropriate to increase the diamorphine dose or even consider treatment with a non-steroidal anti-inflammatory drug. The increase in midazolam dose to 80mg/24 hr would simply make Mr Cunningham less conscious than he already appears to have been (there is not a clear description of his conscious level at this stage).
- 3.19 The increase in hyoscine dose to 800microg/24 hr is also difficult to justify when there is no record that the management of bronchial secretions was a problem. The subsequent threefold increase in diamorphine dose later that day to 60mg/24 hr is in my view very poor practice. Such an increase was highly likely to result in respiratory depression and marked depression of conscious level, both of which could lead to premature death. The description of Mr Cunningham, was that analgesia was 'just' controlling pain and a more cautious increase in diamorphine dose, certainly no more than two fold, was indicated with careful review of respiratory status and conscious level after steady state levels of diamorphine would have been obtained about 20 hours later. A more appropriate response to deal with any acute breakthrough pain is to administer a single prn (intermittent) dose of opiate by the oral or intramuscular route, depending on whether Mr Cunningham was unable to swallow at this time.
- 3.20 The increase in both diamorphine dose and midazolam dose on 26th September is difficult to justify when there is no record in the medical or nursing notes that Mr Cunningham's pain was uncontrolled. Although it is possible to accept the increase in diamorphine dose may have been appropriate if Mr Cunningham

was observed to be in pain, I find the further increase in midazolam dose to 100 mg/24hr of great concern. I would anticipate that this dose of midazolam administered with 80 mg/24hr of diamorphine would be virtually certain to produce respiratory depression and severe depression of conscious level. This would be expected to result in death in a frail individual such as Mr Cunningham. I would expect to see very clear reasons for the use of such doses recorded in the medical notes.

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3.21 I can find no record of Mr Cunningham receiving food or fluids following his admission on 21st September despite a note from Dr Lord that Mr Cunningham was to receive a 'high protein diet'. There is no indication in the medical or nursing notes as to whether this had been discussed, but given that Mr Cunningham was admitted with the intention of returning to his Nursing Home (it was to be held open for 3 weeks) I would expect the notes to record a clear discussion and decision making process involving senior medical staff accounting for the decision to not administer subcutaneous fluids and/or nasogastric nutrition once Mr Cunningham was commenced on drugs which may have made him unable to swallow fluids or food.

Recorded causes of death

3.22 The recorded cause of death was bronchopneumonia with contributory causes of Parkinson's disease and sacral ulcer. A post mortem was not obtained and the recorded causes were in my opinion reasonable. It is possible that Mr Cunningham died from drug induced respiratory depression without bronchopneumonia present or from the combined effects of bronchopneumonia and drug-induced respiratory depression. Mr Cunningham was at high risk of developing pneumonia even if he had not received sedative or opiate drugs, bronchopneumonia can occur as a secondary complication of opiate and sedative induced respiratory depression. In the absence of post-mortem, radiological data (chest Xray) or recordings of Mr Cunningham's respiratory rate I would consider the recorded cause of death of bronchopneumonia as reasonable. Even if the staff had considered Mr Cunningham had drug-induced respiratory depression as a contributory factor, it would not be usual medical practice to enter this as a contributory cause of death where the administration of such drugs was considered appropriate for symptom relief.

Duty of care issues

3.23 Medical and nursing staff on Dryad ward had a duty of care to deliver medical and nursing care to attempt to heal Mr Cunningham's sacral ulcer and to document the effects of drugs prescribed. In my opinion this duty of are was not adequately met and the denial of fluid and diet and prescription of high doses of diamorphine and midazolam was poor practice and may have contributed to Mr Cunningham's death.

Summary

3.24 In summary although Mr Cunningham was admitted for medical and nursing care to attempt to heal and control pain from his sacral ulcer, Dr Barton and the ward staff appear to have considered Mr Cunningham was dying and had been admitted for terminal care. The medical and nursing records are inadequate in documenting his clinical state at this time. The initial prescription of

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subcutaneous diamorphine, midazolam and hyoscine by Dr Barton was in my view reckless. The dose increases undertaken by nursing staff were inappropriate if not undertaken after medical assessment and review of Mr Cunningham. I consider it highly likely that Mr Cunningham experienced respiratory depression and profound depression of conscious level due to the infusion of diamorphine and midazolam. I consider the doses of these drugs prescribed and administered were inappropriate and that these drugs most likely contributed to his death through pneumonia and/or respiratory depression.

ALICE WILKIE

Course of Events

- Alice Wilkie was 81 years old when admitted under the care of Dr Lord, by her general practitioner on 31st July 1998 from Addenbrooke Rest Home to Phillip Ward, Department of Medicine for Elderly People, at the Queen Alexandra Hospital, Portsmouth. The general practitioner referral letter states "This demented lady has been in this psychogeriatric care home for a year. She had a UTI early this week and has not responded to trimethoprim. Having fallen last night, she is not refusing fluids and is becoming a little dry". The medical admitting notes record she was taking prozac (fluoxetine) syrup 20 mg once daily, codanthramer 5-10ml nocte, lactulose 10ml once daily zopiclone 1.875 or 3.75mg nocte and promazine syrup 25mg as required. On examination she had a fever and bilateral conjunctivitis but no other significant findings. The admitting doctor diagnosed a urinary tract infection and commenced intravenous antibiotics to be administered after a blood culture and catheter specimen of urine had been obtained. The following day DNR (do not resuscitate) is recorded in the notes. On 3rd August 1998 the medical notes record the fever had settled, that she was taking some fluids orally, was taking the antibiotic Augmentin elixir orally and receiving subcutaneous fluids. The notes then record (date not clear) that her Mental Test Score was 0/10 and Barthel 1/20 (indicating severe dependency). Mrs Wilkie was to be transferred to Daedalus NHS continuing care ward on 6th August 1998 with a note that her bed was to be kept at Addenbrooke Rest Home.
- 4.2 Following transfer on 6th August an entry in the medical notes states "Transferred from Phillips Ward. For 4-6/52 only. On Augmentin for UTI". Dr Lord writes on 10th August 1998 'Barthel 2/20. Eating and drinking better. Confused and slow. Give up place at Addenbrooke's. R/V (review) in 1/12 (one month) –if no specialist medical or nursing problems D (discharge) to a N/Home. Stop fluoxetine'. The next entry is by Dr Barton on 21st August "Marked deterioration over last few days. sc analgesia commenced yesterday. Family aware and happy". The final entry is on the same day at 1830h where death is confirmed. The most recent record of the patient's weight I can find is 56Kg in April 1994.
- 4.3 The nursing notes, which have daily entries during her one week stay on Phillip ward note she was catheterised, was confused at times and was sleeping well prior to transfer. The nursing notes on Daedalus ward record "6/8/98 Transferred from Philip ward QAH for 4-6 weeks assessment and observation and then decide on placement. Medical history of advanced dementia, urinary tract infection and dehydration" and that she was seen by Dr Peters. The nursing assessment sheet notes "does have pain at times unable to ascertain where". The nutrition care plan states on 6th August 1998 "Due to dementia" patient has a poor dietary intake". And dietary intake is recorded between 12th August and 18th August but not before or following these dates. Nursing entries in the contact record state on 17th August 1998 "Condition has generally deteriorated over the weekend Daughter seen- aware that mums condition is worsening, agrees active treatment not appropriate and to use of syringe driver if Mrs Wilkie is in pain". There is no entry in the notes on 20th August or preceding few days indicating Mrs Wilkie was in pain.

- 4.4 A nursing entry on 21st August 1998 at 1255h states "Condition deteriorating during morning. Daughter and granddaughters visited and stayed. Patient comfortable and pain free". There are a number of routine entries in the period 6th August 1998 to death on 21st August 1998 in nutrition, pressure area care, constipation, catheter care, and personal hygiene. The nursing care plan records no significant deterioration until 21st August where it is noted death was pronounced at 2120h by staff nurse Sylvia Roberts. Cause of death was recorded as bronchopneumonia.
- 4.5 The drug charts records that Dr Barton prescribed as a regular daily review (not intermittent as required) prescription diamorphine 20-200mg/24hr, hyoscine 200-800microg/24hr and midazolam 20-80mg/24hr all to be administered subcutaneously. The prescription is not dated. Drugs were first administered on 20th August, diamorphine at 30mg/24hr and midazolam 20mg/24hr from 1350h and then again on 21st August. Mrs Wilkie had not been prescribed or administered any analgesic drugs during her admission to Daedalus ward prior to administration of the diamorphine and midazolam infusions. During the period 16th-18th August she was prescribed and received zopiclone (a sedative hypnotic) 3.75mg nocte and co-danthramer 5-10ml (a laxative) orally.

Opinion on patient management

Leadership, roles, responsibilities and communication in respect of the clinicians involved

4.6 Primary responsibility for the medical care of Mrs Wilkie during her admission to Daedalus ward lay with Dr Lord, as the consultant responsible for her care. She saw Mrs Wilkie on 10th August 1998, 11 days prior to her death. My understanding is that day-to-day medical care was the responsibility of the clinical assistant Dr Barton and during out of hours period the on call doctor based at the Queen Alexander Hospital. Ward nursing staff were responsible for assessing and monitoring Mrs Wilkie and informing medical staff of any significant deterioration.

Accuracy of diagnosis and prognosis including risk assessments

4.7 The initial diagnosis of a urinary tract infection and dehydration was reasonable and appears correct. Mrs Wilkie had a diagnosis of dementia, which there was clear evidence for. The entry by Dr Lord on 10th August 1998 provides a reasonable assessment of her functional level at this time, and a plan to review appropriate placement in one month's time. No diagnosis was made to explain the deterioration Mrs Wilkie is reported to have experienced around 15th August. There is no medical assessment in the notes following 10th August except documentation on 21st August 1998 of a marked deterioration. There is no clear evidence that Mrs Wilkie was in pain although she was commenced on opiate analgesics.

Evaluation of drugs prescribed and the administration regimens

4.8 No information is recorded in the medical or nursing notes to explain why Mrs Wilkie was commenced on diamorphine and hyoscine infusions. In my opinion there was no indication for the use of diamorphine and hyoscine in Mrs Wilkie. Other oral analgesics, such as paracetamol and mild opiate drugs could and should first have been tried, if Mrs Wilkie was in pain, although there is no evidence that she was. If these were inadequate oral morphine would have



been the next appropriate choice. From the information I have seen in the notes it appears the diamorphine and midazolam may have been commenced for non-specific reasons, perhaps as a non-defined palliative reasons as it was judged she was likely to die in the near future.

4.9 I consider the undated prescription by Dr Barton of subcutaneous diamorphine 20-200mg/24hr prn, hyoscine 200-800microg/24hr and midazolam 20-80mg/24hr to be poor practice and potentially very hazardous. I consider it poor and hazardous management to initially commence both diamorphine and midazolam in a frail elderly underweight patient with dementia such as Mrs Wilkie. The combination could result in profound respiratory depression and it would have been more appropriate to review the response to diamorphine alone before commencing midazolam, had it been appropriate to commence subcutaneous analgesia, which as I have stated before was not the case.

Quality and sufficiency of the medical records

4.10 The medical and nursing records during her stay on Daedalus ward are inadequate not sufficiently detailed, and do not provide a clear picture of Mrs Wilkie's condition. In my opinion the standard of the notes falls below the expected level of documentation on a continuing care or rehabilitation ward. The assessment by Dr Lord on 10th August 1998 is the only satisfactory medical note entry during her 15 day stay on Daedalus ward.

Appropriateness and justification of the decisions that were made

4.11 As discussed above I do not consider the decision to commence diamorphine and hyoscine was appropriate on the basis of the information recorded in the clinical notes.

Recorded causes of death

4.12 There was no specific evidence that bronchopneumonia was present, although this is a common pre-terminal event in frail older people, and is often entered as the final cause of death in frail older patients. I am surprised the death certificate did not apparently refer to Mrs Wilkie's dementia as a contributory cause. It is possible Mrs Wilkie's death was due at least in part to respiratory depression from the diamorphine she received, or that the diamorphine led to the development of bronchopneumonia. However since there are no clear observations of Mrs Wilkie's respiratory observations it is difficult to know whether respiratory depression was present Mrs Wilkie deteriorated prior to administration of diamorphine and midazolam infusion, and in view of this, my opinion would be that although the opiate and sedative drugs administered may have hastened death, and these drugs were not indicated, Mrs Wilkie may well have died at the time she did even if she had not received the diamorphine and midazolam infusions.

Duty of care issues

4.13 Medical and nursing staff on Daedalus ward had a duty of care to deliver medical and nursing care, to monitor, and to document the effects of drugs prescribed to Mrs Wilkie. In my opinion this duty of care was not adequately met, the prescription of diamorphine and midazolam was poor practice and this may have contributed to Mrs Wilkie's death.

Summary

4.14 In my opinion the prescription of subcutaneous diamorphine and midazolam was inappropriate, and probably resulted in depressed conscious level and respiratory depression, which may have hastened her death. However Mrs Wilkie was a frail very dependent lady with dementia who was at high risk of developing pneumonia. It is possible she would have died from pneumonia even if she had not been administered the subcutaneous sedative and opiate drugs.

Robert WILSON

- 5.1 Mr Wilson was 75 years old man when he was admitted to Queen Alexandra Hospital on 22nd September 1998 after he sustained a proximal fracture of the left humerus. He was treated with morphine, initially administered intravenously and then subcutaneously. He developed vomiting. On 24th September he was given 5mg diamorphine and lost sensation in the left hand. On 29th September an entry in the medical notes states "ref to social worker, review resus status. Not for resuscitation in view of quality of life and poor prognosis".
- On 7th October the notes record he was "not keen on residential home and 5.2 wished to return to his own home". Dr Lusznat, Consultant in Old Age Psychiatry on 8th October 1998, saw him. Dr Lusznat's letter on 8th October notes that Mr Wilson had been sleepy and withdrawn and low in mood but was now eating and drinking well and appeared brighter in mood. His Barthel score was 5/20. Dr Lusznat noted he had a heavy alcohol intake during the last 5 years. At the time he was seen by Dr Lusznat her was prescribed thiamine 100 mg daily, multivitamins two tablets daily, senna two tablets daily, magnesium hydroxide 10 mls twice daily and paracetamol 1g four time daily. On examination he had mildly impaired cognitive function (Mini Mental State Examination 24/30). Dr Lusznat considered Mr Wilson might have developed an early dementia, which could have been alcohol related, Alzheimer's disease or vascular dementia. An antidepressant trazadone 50mg nocte was commenced. Dr Lusznat states at the end of her letter "On the practical side he may well require nursing home care though at the moment he is strongly opposed to that idea I shall be happy to arrange follow up by our team once we know when and where he is going to be discharged". On 13th October the medical notes record a ward round took place, that he required both nursing and medical care, was at risk of falling and that a short spell in long-term NHS care would be appropriate. Reviewing the drug charts Mr Wilson was taking regular soluble paracetamol (1g four times daily) and codeine phosphate 30mg as required for pain. Between 8th and 13th October Mr Wilson was administered four doses of 30mg codeine. Mr Wilson's weight in March 1997 was 93Kg
- 5.3 On the 14th October Mr Wilson was transferred to Dryad Ward. An entry in the medical notes by Dr Barton reads "Transfer to Dryad ward continuing care. HPC fracture humerus. needs help with ADL (activities of Daily Living), hoisting, continent, Barthel 7. Lives with wife. Plan further mobilisation". On 16th November the notes record; 'Decline overnight with S.O.B. o/e? weak pulse. Unresponsive to spoken work. Oedema ++ in arms and legs. Diagnosis? silent MI, ? decreased __ function. ↑ frusemide to 2 x 40mg om'. On 17th October the notes record 'comfortable but rapid deterioration' On 18th October staff nurse Collins records death at 2340h. Cause of death is recorded as congestive cardiac failure.
- 5.4 Nursing notes state in the summary section on 14th October "History of left humerus fracture, arm in collar and cuff. Long history of heavy drinking. LVF chronic oedematous legs. S/B Dr Barton. Oramorph 10mg/5ml given. Continent of urine uses bottles". On 15th October "Commenced oramorph 10mg/5ml 4 hrly for pain in L arm. Wife seen by sis. Hamblin who explained Robert's condition is poor". An earlier note states "settled and slept well". On 16th October "seen by Dr Knapman an as deteriorated over night. Increase

frusemide to 80mgdaily. For A.N.C (active nursing care)". Later that day a further entry states "Patient very bubbly chest this pm. Syringe driver commenced 20mg diamorphine, 400mcgs hyoscine. Explained to family reason for driver". A separate note on 16th October in the nursing care plan states "More secretions—pharyngeal—during the night, but Robert hasn't been distressed. Appears comfortable". On 17th October 0515h "Hyoscine increased to 600mcgs as oro-pharyngeal secretions increasing. Diamorphine 20mg." Later that day a further entry states "Slow deterioration in already poor condition. Requiring suction very regularly—copious amounts suctioned. Syringe driver reviewed at 15.50 s/c diamorphine 40mg, midazolam 20mcgs, hyoscine 800 mcgs". A later note states "night: noisy secretions but not distressing Robert. Suction given as required during night. Appears comfortable". On 18th October "further deterioration in already poor condition. Syringe driver reviewed at 14:40 s/c diamorphine 60mg, midazolam 40mg, hyoscine 1200mcg. Continues to require regular suction".

- 5.5 The medication charts record administration of the following drugs:
 - 14 Sep 1445h oramorph 10mg

2345h oramorph 10mg

- 16 Sep 1610h diamorphine 20mg/24 hr, hyoscine 400 microg/24hr subcutaneous infusion
- 17 Sep 0515h diamorphine 20mg/24hr, hyoscine 600 microg/24hr 1550h diamorphine 40mg/24hr, hyoscine 800 microg/24hr midazolam 20mg/24hr

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Sep 1450h diamorphine 60mg/24hr, hyoscine 1200 microg/24hr midazolam 40mg/24hr Frusemide was administered at a dose of 80mg daily at 0900h on 15th and 16th October. An additional 80 mg oral dose was administered at an unstated time on 16th October.

Opinion on patient management

Leadership, roles, responsibilities and communication in respect of the clinicians involved

- 5.6 Responsibility for the care of Mr Wilson during his admission to Dryad ward lay with Dr Lord as the consultant responsible for his care. My understanding is that day to day medical care was delegated to the clinical assistant Dr Barton and during the out of hours responsibility was with the on call doctor based at Queen Alexandra Hospital. Ward nursing staff were responsible for assessing and monitoring Mr Wilson and informing medical staff of any significant deterioration.
- 5.7 Dr Lusznat was responsible for assessing Mr Wilson and making further recommendations concerning his future care when he was seen at Queen Alexandra Hospital.

Accuracy of diagnosis and prognosis including risk assessments

5.8 Dr Barton assessed Mr Wilson on 14th October the day he was transferred to Dyad ward. There was a plan to attempt to improve his mobilisation through rehabilitation. There is no record of any significant symptomatic medical problems, in particular any record that Mr Wilson was in pain in the medical

notes. The nursing notes suggest Mr Wilson was prescribed oramorph for pain in his arm following his admission to Dryad Ward. He was prescribed paracetamol to take as required but did not receive any paracetamol whilst on Dryad Ward.

- 5.9 Mr Wilson deteriorated on 15th September when he became short of breath. The working diagnosis was of heart failure due to a myocardial infarct. I do not consider the assessment by the on call doctor of Mr Wilson was adequate or competent. There is no record of his blood pressure, clinical examination findings in the chest (which might have indicated whether he had signs of pulmonary oedema or pneumonia). In my opinion an ECG should have been obtained that night, and a Chest Xray obtained the following morning to provide supporting evidence for the diagnosis. Mr Wilson was admitted for rehabilitation not terminal care and it was necessary and appropriate to perform reasonable clinical assessments and investigations to make a correct diagnosis.
- 5.10 Following treatment Mr Wilson was noted to have had a rapid deterioration. The medical and nursing teams appear to have failed to consider that Mr Wilson's deterioration may have been due to the diamorphine infusion. In my opinion when Mr Wilson was unconscious the diamorphine infusion should have been reduced or discontinued. The nursing and medical staff failed to record Mr Wilson's respiratory rate, which was likely to have been reduced, because of respiratory depressant effects of the diamorphine. The diamorphine and hyoscine infusion should have been discontinued to determine whether this was contributing to his deteriorating state. There is no record of the reason for the prescribing of the midazolam infusion commenced the day before his death. At this time the nursing notes record he was comfortable. Mr Wilson did not improve. The medical and nursing teams did not appear to consider that the diamorphine, hyoscine and midazolam infusion could be a major contributory factor in Mr Wilson's subsequent decline. The infusion should have been discontinued and the need for this treatment, in my opinion unnecessary at the time of commencement, reviewed.

Evaluation of drugs prescribed and the administration regimens

- 5.11 The initial prescription and administration of oramorph to Mr Wilson following his transfer to Dryad ward was in my opinion inappropriate. His pain had been controlled with regular paracetamol and as required codeine phosphate (a mild opiate) prior to his transfer, and in the first instance these should have been discontinued.
- 5.12 I am unable to establish when Dr Barton wrote the prescription for subcutaneous diamorphine 20-200mg/24hr, hyoscine 200-800microg/24hr, and midazolam 20-80mg/24hr as these are undated. The administration of diamorphine and hyoscine by subcutaneous infusion as a treatment for the diagnosis of a silent myocardial infarction was in my opinion inappropriate. The prescription of a single dose of intravenous opiate is standard treatment for a patient with chest pain following myocardial infarction is appropriate standard practice but was not indicated in Mr Wilson's case as he did not have pain. The prescription of an initial single dose of diamorphine is appropriate as a treatment for pulmonary oedema if a patient fails to respond to intravenous diuretics such as frusemide. Mr Wilson was not administered intravenous frusemide or another loop diuretic. Instead only a single additional oral dose of frusemide

was administered. In my opinion this was an inadequate response to Mr Wilson's deterioration. The prescription of continuous subcutaneous infusion of diamorphine and hyoscine is not appropriate treatment for a patient who is pain free with a diagnosis of a myocardial infarction and heart failure. When opiates are used to treat heart failure, close monitoring of blood pressure and respiratory rate, preferably with monitoring of oxygen saturation is required. This was not undertaken.

5.13 The increase in diamorphine dose to 40mg/24hr and then 60mg/24 hr in the following 48 hours is not appropriate when the nursing and medical notes record no evidence that Mr Wilson was in pain or distressed at this time. This was poor practice and potentially very hazardous. Similarly the addition of midazolam and subsequent increase in dose to 40mg/24hr was in my opinion highly inappropriate and would be expected to carry a high risk of producing profound depression of conscious level and respiratory drive.

Quality and sufficiency of the medical records

5.14 The initial entry in the medical records by Dr Barton on 14th October is reasonable and sufficient. The subsequent entries relating to Mr Wilson's deterioration are in my opinion inadequate, and greater detail and the results of examination findings should have been recorded. No justification for the increases in diamorphine, midazolam and hyoscine dose are written in the medical notes. The nursing notes are generally of adequate quality but I can find no record of fluid and food intake by Mr Wilson.

Appropriateness and justification of the decisions that were made

5.15 I consider the prescription of oramorph was inappropriate. The subsequent prescription and administration of diamorphine, hyoscine and midazolam was highly inappropriate, not justified by information presented in the notes and could be expected to result in profound depression of conscious level and respiratory depression in a frail elderly man such as Mr Wilson.

Recorded causes of death

5.16 The recorded cause of death was congestive cardiac failure. The limited clinical information recorded in the absence of a chest Xray result or post-mortem findings, suggest this may have been the cause of Mr Wilson's death. However in my opinion it is highly likely that the diamorphine, hyoscine and midazolam infusion led to respiratory depression and/or bronchopneumonia and it is possible that Mr Wilson died from drug induced respiratory depression.

Duty of care issues

5.17 Medical and nursing staff on Dryad ward had a duty of care to deliver appropriate medical and nursing care to Mr Wilson, and to monitor the effects of drugs prescribed. In my opinion this duty of care was not adequate. The administration of high doses of diamorphine and midazolam was poor practice and may have contributed to Mr Wilson's death.

Summary

5.18 Mr Wilson was a frail elderly man with early dementia who was physically dependent. Following his admission to Dryad ward he was, in my opinion,

inappropriately treated with high doses of opiate and sedative drugs. These drugs are likely to have produced respiratory depression and/or the development of bronchopneumonia and may have contributed to his death.

Eva PAGE

- Eva Page was 87 years old when admitted as an emergency on 6th February 1998 to the Department of Medicine for Elderly People at Queen Alexandra Hospital. The medical notes record that she had experienced a general deterioration over the last 5 days was complaining of nausea and reduced appetite and was dehydrated. She had felt 'depressed' during the last few weeks. On admission she was taking ramipril 5mg once daily (a treatment for heart failure and hypertension), frusemide 40mg once daily (treatment for fluid retention), digoxin 125microg once daily (to control irregular heart rate), sotalol 40 mg twice daily (to control irregular heart rate), aspirin 75 mg once daily (to prevent stroke and myocardial infarction) and sertraline 50mg once daily (an antidepressant commenced by her general practitioner on 26th January 1998). A discharge summary and medical notes relating to an admission in May 1997 states that she was admitted with acute confusion, had reduced movement on the right side and was discharged back to her residential home on aspirin. No admitting diagnosis is recorded in the clerking notes written by Code A on 6th February 1998 but they record that "patient refuses iv fluids and is willing to accept increased oral fluids".
- 6.2 On 7th February 1998 the medical notes record an opacity seen on the chest Xray and sate "mood low. Feels frightened –doesn't know why. Nausea and ??. Little else. Nil clinically." An increased white cell count is noted (13.0) and antibiotics commenced. A subsequent chest Xray report (undated) states there is a 5cm mass superimposed on the left hilum highly suspicious of malignancy. The medical notes on 11 February 1998 record this at the Xray meeting. On 12th February 1998 the notes record (? Dr Shain) 'In view of advanced age aim in the management should be palliative care. Charles Ward is suitable. Not for CPR'. On 13th February the notes record 'remains v low Appears to have 'given up' d/w son re probably diagnosis d/w RH (residential home) re ability to cope'. The notes record 'son agrees not suitable for invasive Tx (treatment). Matron from RH visiting today will check on ability to cope'.
- 6.3 On 19th February the notes record she fell on the ward and experienced minor cuts. On 16th February 'gradual deterioration, no pain, confused. For Charles Ward she could be discharged to community from Charles Ward' On 19th February the notes summarise her problems 'probable Carcinoma of the bronchus, previous left ventricular failure, atrial fibrillation, digoxin toxicity and a transient ischaemic attack, that she was sleepy but responsive, states that she is frightened but doesn't know why. Says she has forgotten things, not possible to elicit what she can't remember, low MTS (mental test score). Plan encourage oral fluids, s/c fluid over night if tolerated. Continue antidepressants'. On 18th February the medical notes state "No change. Awaiting Charles Ward bed".
- 6.4 The nursing notes record she was confused but mobilised independently. On 19th February she was transferred to Charles Ward instead of the preferred option of a bed at Gosport Hospital, which the notes record was full ('no beds'). The Queen Alexandra Hospital medical notes record a summary of her problems on 19th February prior to transfer as follows " *Diagnosis CA bronchus probable [no histology] Diag based on CXR. PMH 95 LVF + AF 95 Digoxin toxicity 97 TIA. Admitted 6.2.98 general deterioration CXR ? Ca Bronchus. Well*

defined O lesion. Exam: sleepy but responsive answers appropriately. States that she is frightened but doesn't know why. Says she has forgotten things. Not possible to elicit what she can't remember. Low MTS" and "Feels in general tired and very thirsty. Plan encourage oral fluids, s/c fluid overnight is tolerated continue antidepressants".

- 6.5 The medical notes on 23rd February record diagnoses of depression, dementia, ? Ca bronchus, ischaemic heart disease and congestive heart failure. On 25th February Dr Lord records in the medical notes "confused and some agitation towards afternoon evening try tds (three times daily) thioridazine, son in Gosport, transfer to Gosport 27/2, heminevrin prn nocte'. A further entry states 'All other drugs stopped by Dr Lord'.
- 6.6 Mrs Page was transferred to Dryad ward at Gosport War Memorial Hospital on 27th February 1998. Dr Barton writes in the medical notes "Transfer to Dryad ward continuing care, Diagnosis of Ca Bronchus on CXR on admission. Generally unwell off legs, not eating, bronchoscopy not done, catheterised, needs help with eating and drinking, needs hoisting. Barthel 0. Family seen and well aware of prognosis. Opiates commenced. I'm happy for nursing staff to confirm death". The nursing notes state she was admitted for 'palliative care', that she had a urinary catheter (inserted on 22nd February 1998) was incontinent of faeces, and was dependent for washing and dressing but could hold a beaker and pick up small amounts of food. Barthel Index was 2/20. The nursing action plan states 'encourage adequate fluid intake.' On 28th February an entry in the medical notes by Dr Laing (duty GP) record 'asked to see: confused. Feels 'lost' agitated esp. night/evening, not in pain, to give thioridazine 25mg tds regular, heminevrin noct. The nursing notes record she was very distressed and that she was administered thioridazine and Oramorph 2.5ml.
- 6.7 On 2nd March Dr Barton records 'no improvement on major tranquillisers. I suggest adequate opioids to control fear and pain; Son to be seen by Dr Lord today'. A subsequent entry by Dr Lord on the same day states 'spitting out thioridazine, quieter on prn sc diamorphine. Fentanyl patch started today. Agitated and calling out even when staff present (diagnoses) 1) Ca Bronchus 2)? Cerebral metastases. -ct (continue) fentanyl patches.' A further entry by Dr Lord that day records 'son seen. Concerned about deterioration today. Explained about agitation and that drowsiness was probably due in part to diamorphine. He accepts that his mother is dying and agrees we continue present plan of Mx (management)".
- 6.8 On 2nd March the nursing notes record "commenced on Fentanyl 25mcg this am. Very distressed this morning seen by Dr Barton to have and diamorphine 5mg i/m (intramuscular) same given 0810h by a syringe driver. A further entry the same day states "S/B Dr Lord. Diamorphine 5mg i/m given for syringe driver with diamorphine loaded". On 3rd March a rapid deterioration in Mrs Page's condition is recorded 'Neck and left side of body rigid –right side rigid, At 1050h diamorphine and midazolam were commenced by syringe driver. Death is recorded later that day at 2130h, 4 days following admission to Dyad ward.
- 6.9 The prescription charts (which are incompletely copied in notes made available to me) indicate she received the following drugs during this admission Two

doses of intramuscular diamorphine 5 mg were administered at 0800 and 1500h (date not visible)

Feb 1998 1300h thioridazine 25mg

1620h oramorph 5mg

2200h heminevrin 250mg in 5ml

1 Mar 1998 0700h thioridazine 25 mg

1300h thioridazine 25 mg

2200h heminevrin 250mg

2 Mar 1998 0700h thioridazine 25mg

0800h fentanyl 25microg

3 Mar 1998 1050h diamorphine 20mg/24hr, midazolam 20 mg/24hr

by subcutaneous infusion

On 27th February Dr Barton prescribed thioridazine 25mg (prn tds) and Oramorph (10mg/5ml) 4hrly prn. On 2nd March Dr Barton prescribed fentanyl 25microg patch (x3 days) to take as required (prn). On 3rd March Dr Barton prescribed diamorphine 20-200mg/24hr, hyoscine 200-800ucg/24hr and midazolam 20-80mg/24hr by subcutaneous infusion.

The notes do not indicate that the fentanyl patch was removed and I would assume this was continued when the diamorphine and midazolam infusion was commenced.

Opinion on patient management

Leadership, roles, responsibilities and communication in respect of the clinicians involved

6.10 Primary responsibility for the medical care of Mrs Page during her admission to Dryad Ward lay with Dr Lord, as the consultant responsible for his care. She saw Mrs Page 2 days before her transfer to Dryad ward and two days following her admission, the day before she died. My understanding is that day-to-day medical care was the responsibility of the clinical assistant Dr Barton and during out of hours period the on call doctor based at the Queen Alexander Hospital. Ward nursing staff were responsible for assessing and monitoring Mrs Page and informing medical staff of any significant deterioration.

Accuracy of diagnosis and prognosis including risk assessments

6.11 The assessment and management of Mrs Page at Alexandra Hospital was in my opinion competent and considered. From the information in the clinical notes I would agree with the diagnosis of probable carcinoma of bronchus. The decision to prescribe an antidepressant was in my opinion appropriate. Prior to transfer to Dryad ward she was not in pain but was transferred for palliative care. Although Mrs Page was clearly very dependent and unwell, it is not clear why Dr Barton prescribed opiates to Mrs Page on admission to Dryad ward when there is no evidence she was in pain. I suspect the reason was to provide relief for Mrs Page's anxiety and agitation. This is a reasonable indication for opiates in the palliative care of a patient with known inoperable carcinoma. Mrs Page was noted to be severely dependent, Barthel Index 0, and in conjunction with a probable carcinoma of the bronchus the assessment that she required palliative care and was likely to die in the near future was appropriate.

Evaluation of drugs prescribed and the administration regimens

6.12 The prescription of the major tranquilliser thioridazine for anxiety was reasonable and appropriate. The prescribing of the sedative/hypnotic drug heminevrin was similarly reasonable although potential problems of sedation

from the combination need to be considered. Mrs Page was not in pain but I consider the prescription of oramorph on 28th February to attempt to improve her distress was reasonable. By 2nd March Mrs Page remained very distressed despite prescription of Oramorph, thioridazine and heminevrin. Since the notes reported she was more settled following intramuscular diamorphine and she had been spitting out her oral medication, I would consider it appropriate to prescribe a transdermal fentanyl patch to provide continuing opioid drugs to Mrs Page. The lowest dose patch was administered but it would have been important to be aware of the potential for depression of respiration and/or conscious level that could occur.

6.13 I do not understand why subcutaneous diamorphine and midazolam infusions were commenced on 3rd March when Mrs Page had deteriorated whilst on the fentanyl patch. There is no indication in the notes that Mrs Page was in pain or distressed. The notes describe her as having undergone a rapid deterioration, which could have been due to a number of different causes, including a stroke or an adverse effect of the fentanyl patch. In my opinion the prescription by Dr Barton of subcutaneous diamorphine 20-200mg/24hr prn, hyoscine 200-800microg/24hr and midazolam 20-80mg/24hr was poor practice and potentially very hazardous. I would judge it poor management to initially commence both diamorphine and midazolam in a frail elderly underweight patient such as Mrs Page who was already receiving transdermal fentanyl. I would expect very clear reasons to support the use of the drugs to be recorded in the medical notes. The combination could result in profound respiratory depression and there are no symptoms recorded which suggest the administration of either drug was appropriate.

Quality and sufficiency of the medical records

6.14 The medical and nursing records relating to Mrs Page's admission to Dryad ward are in my view of adequate quality, although as stated above the reasons for the use of midazolam and diamorphine are not recorded in either the medical or nursing notes.

Appropriateness and justification of the decisions that were made

6.15 In my opinion the majority of management and prescribing decisions made by medical and nursing staff were appropriate. The exception is the prescription of diamorphine and midazolam on the day of Mrs Page's death. From the information I have seen in the notes it appears that Dr Barton may have commenced the diamorphine and midazolam infusion for non-specific reasons or for non-defined palliative reasons when it was judged she was likely to die in the near future.

Recorded causes of death

6.16 In the absence of a post-mortem the recorded cause of death is reasonable. Mrs Page had a probable carcinoma of the bronchus and experienced a slow deterioration in her general health and functional abilities. It is possible that Mrs Page died from drug induced respiratory depression. However Mrs Page was at high risk of dying from the effects of her probable carcinoma of the bronchus even if she had not received sedative and opiate drugs. Bronchopneumonia can also occur as a complication of opiate and sedative induced respiratory depression but also in patients deteriorating from malignancy. In the absence of post-mortem, radiological data (chest Xray) or recordings of Mrs Page's

respiratory rate I would consider the recorded cause of death was possible. The deterioration on between the 2nd March and 3rd March could have been secondary to the fentanyl patch she received but again could have occurred in the absence of receiving this drug. There are no accurate records of Mrs Page's respiratory rate but significant potentially fatal respiratory depression was likely to have resulted could have resulted from the combination of diamorphine, midazolam and fentanyl.

Duty of care issues

6.17 Medical and nursing staff on Dryad ward had a duty of care to deliver medical and nursing care, to monitor Mrs Page and to document the effects of drugs prescribed. In my opinion this duty of care was adequately met except during the last day of her life when the prescription of diamorphine and midazolam was poor practice and may have contributed to Mrs Wilkie's death.

Summary

6.18 Mrs Page was a frail elderly lady with probable carcinoma of the bronchus who had been deteriorating during the two weeks prior to admission to Dryad ward. In general I consider the medical and nursing care she received was appropriate and of adequate quality. However I cannot identify a reason for the prescription of subcutaneous diamorphine, midazolam and hyoscine by Dr Barton on the 3rd March. In my view this was an inappropriate, potentially hazardous prescription. I would consider it highly likely that Mrs Page experienced respiratory depression and profound depression of conscious level from the combination of these two drugs and fentanyl but I cannot exclude other causes for her deterioration and death at this time such as stroke or pneumonia.

Opinion on clinical management at Gosport War Memorial Hospital based on review of five cases presented by Hampshire Police

- 7.1 My opinion on the five cases I have been asked to review at Gosport War Memorial Hospital must be considered in context. My understanding is that the five cases have been selected by Hampshire Police because of concerns expressed relating to the management of these patients. Therefore my comments should not be interpreted as an opinion on the quality of care in general at Gosport War Memorial Hospital or of the general quality of care by the clinicians involved. My comments also relate to a period 2-4 years ago and the current clinical practice at the hospital may be very different today. An opinion on the quality of care in general at the hospital or of the clinicians would require a systematic review of cases, selected at random or with pre-defined patient characteristics. Examination of selected cases is not an appropriate mechanism to comment on the general quality of care of an institution or individual practitioners.
- 7.2 However having reviewed the five cases I would consider they raise a number of concerns that merit further examination by independent enquiry. Such enquiries could be made through further police interviews or perhaps more appropriately through mechanisms within the National Health Service, such as the Commission for Health Improvement, and professional medical and nursing bodies such as the General Medical Council or United Kingdom Central Council for Nursery, Midwifery and Health Visiting.
- 7.3 My principle concerns relate to the following three areas of practice: prescription and administration of subcutaneous infusions of opiate and sedative drugs in patients with non-malignant disease, lack of training and appropriate medical supervision of decisions made by nursing staff, and the level of nursing and non-consultant medical skills on the wards in relation to the management of older people with rehabilitation needs.
- 7.4 In all five cases subcutaneous infusions of diamorphine and in combination with sedative drugs were administered to older people who were mostly admitted for rehabilitation. One patient with carcinoma of the bronchus was admitted for palliative care. Although intravenous infusion of these drugs are used frequently in intensive care settings, very close monitoring of patients is undertaken to ensure respiratory depression does not occur. Subcutaneous infusion of these drugs is also used in palliative care, but the British National Formulary indicates this route should be used only when the patient is unable to take medicines by mouth, has malignant bowel obstruction or where the patient does not wish to take regular medication (Appendix 2). In only one case were these criteria clearly fulfilled i.e. in Mrs Page who was refusing to take oral medication. Opiate and sedative drugs used were frequently used at excessive doses and in combination with often no indication for dose escalation that took place. There was a failure by medical and nursing staff to recognise or respond to severe adverse effects of depressed respiratory function and conscious level that seemed to have occurred in all five patients. Nursing and medical staff appeared to have little knowledge of the adverse effects of these drugs in older people.

- 7.5 Review of the cases suggested that the decision to commence and increase the dose of diamorphine and sedative drugs might have been made by nursing staff without appropriate consultation with medical staff. There is a possibility that prescriptions of subcutaneous infusions of diamorphine, midazolam and hyoscine may have been routinely written up for many older frail patients admitted to Daedalus and Dryad wards, which nurses then had the discretion to commence. This practice if present was highly inappropriate, hazardous to patients and suggests failure of the senior hospital medical and managerial staff to monitor and supervise care on the ward. Routine use of opiate and sedative drug infusions without clear indications for their use would raise concerns that a culture of "involuntary euthanasia" existed on the ward. Closer enquiry into the ward practice, philosophy and individual staff's understanding of these practices would be necessary to establish whether this was the case. Any problems may have been due to inadequate training in management of older patients. It would be important to examine levels of staffing in relation to patient need during this period, as the failure to keep adequate nursing records could have resulted from under-staffing of the ward. Similarly there may have been inadequate senior medical staff input into the wards, and it would be important to examine this in detail, both in terms of weekly patient contact and in time available to lead practice development on the wards. My review of Dr Lord's medical notes and her statement leads me to conclude she is a competent, thoughtful geriatrician who had a considerable clinical workload during the period the above cases took place.
- 7.6 I consider the five cases raise serious concerns about the general management of older people admitted for rehabilitation on Daedalus and Dryad wards and that the level of skills of nursing and non-consultant medical staff, particularly Dr Barton, were not adequate at the time these patients were admitted.
- 7.7 Having reviewed the five cases presented to me by Hampshire Police, I consider they raise serious concerns about nursing and medical practice on Daedalus and Dryad wards at Gosport War Memorial Hospital. In my opinion a review of practice at the institution is necessary, if this has not already taken place. I would recommend that if criminal proceedings do not take place, that these cases are brought to the attention of the General Medical Council and United Kingdom Central Council for Nursery, Midwifery and Health Visiting, in relation to the professional competence of the medical and nursing staff, and the Commission for Health Improvement, in relation to the quality of service provided to older people in the Trust.

APPENDIX 1

Pharmacology of Opiate and Sedative Drugs

Morphine

Morphine is a potent opiate analgesic considered by many to the 'drug of 8.1 choice' for the control of acute pain (Therapeutic Drugs Dollery). Recommended starting dosage regimens for a fit adult of 70Kg are for intravenous bolus dosing 2.5mg every 5 min until analgesia achieved with monitoring of the duration of pain and dosing interval, or a loading dose of 5-15mg over 30min than 2,5mg –5mg every hour. A standard reference text recommends 'morphine doses should be reduced in elderly patients and titrated to provide optimal pain relief with minimal side effects'. Morphine can be used for sedation where sedation and pain relief are indicated, Dollery comments 'it should be noted that morphine is not indicated as a sedative drug for long-term use. Rather the use of morphine is indicated where the requirement for pain relief and sedation coexist such as in patients admitted to intensive care units and other high dependency areas, the morphine dose should be titrated to provide pain relief and an appropriate level of sedation. Frequently other pharmacological agents (e.g.: benzodiazepines) are added to this regimen to increase the level of sedation".

8.2 Diamorphine

8.3

8.4 Fentanyl

- 8.5 Fentanyl is a transdermal opioid analgesic available as a transdermal patch. The '25' patch releases 25microg/hr.
- 8.6 The British National Formulary (copy of prescribing in palliative care attached Appendix 2) comments on the use of syringe drivers in prescribing in palliative care that drugs can usually be administered by mouth to control symptoms, and that indications for the parenteral route are: patient unable to take medicines by mouth, where there is malignant bowel obstruction, and where the patient does not wish to take regular medication by mouth, It comments that staff using syringe drivers should be adequately trained and that incorrect use of syringe drivers is a common cause of drug errors.

Heminevrin

Midazolam

- 8.1 Midazolam is a benzodiazepine sedative drug. It is used as a hypnotic, preoperative medication, sedation for procedures such as dentistry and GO endoscopy, long-term sedation and induction of general anaesthesia. Iot is not licensed for subcutaneous use, but is described in the British National Formulary prescribing in palliative care section as 'suitable for a very restless patient: it is given in a subcutaneous infusion dose of 20-100mg/24 hrs.
- 8.2 DA standard text describes the use of sedation with midazolam in the intensive care unit setting, and states, "sedation is most commonly met by a combination of a benzodiazepine and an opioid, and midazolam has generally replaced diazepam in this respect". It goes on to state, "in critically ill patients, prolonged sedation may follow the use of midazolam infusions as a result of delayed administration". Potentially life threatening adverse effects are described, "Midazolam can cause dose-related CNS depression, respiratory and

cardiovascular depression. There is a wide variation in susceptibility to its effects, the elderly being particularly sensitive. Respiratory depression, respiratory arrest, hypotension and even death have been reported following its use usually during conscious sedation. The elderly are listed as a high-risk group; the elderly are particularly sensitive to midazolam. The dose should be reduced and the drug given slowly intravenously in a diluted form until the desired response is achieved. In drug interactions the following is stated. "midazolam will also potentiate the central depressant effects of opioids, barbituates, and other sedatives and anaesthetics, and profound and prolonged respiratory depression might result.

8.3

Hyoscine

8.4 The British National Formulary describes hyoscine hydrobromide as an antagonist (blocking drug) of acetylcholine. It reduces salivary and respiratory secretions and provides a degree of amnesia, sedation and antiemesis (antinausea). IN some patients, especially the elderly, hyoscine may cause the central anticholinergic syndrome (excitement, ataxia, hallucinations, behavioural abnormalities, and drowsiness). The palliative care section describes it as being given in a subcutaneous infusion dose of 0.6-2.4mg/24 hours.

8.5

Use of syringe drivers

- The BNF states 'oral medication is usually satisfactory unless there is severe 8.1 nausea and vomiting, dysphagia, weakness, or coma in which case parenteral medication may be necessary. In the pain section it comments the non-opioid analgesics aspirin or paracetamol given regularly will often make the use of opioids unnecessary. An opioid such as codeine or dextropropoxyphene alone or in combination with a non-opioid analgesic at adequate dosage may be helpful in the control of moderate pain id non-opioids are not sufficient. If these preparations are not controlling the pain, morphine is the most useful opioid analgesic. Alternatives to morphine are hydromoprhine, oxycodone and transdermal fentanyl. In prescribing morphine it states 'morphine is given as an oral solution or as standard tablets every 4 hour, the initial dose depending largely on the patient's previous treatment. A dose of 5-10mg is enough to replace a weaker analgesic. If the first dose of morphine is no more effective than the previous analgesic it should be increased by 50% the aim being to choose the lowest dose which prevents pain. The dose should be adjusted with careful assessment of the pain and the use of adjuvant analysics (such as NSAIDs) should also be considered. Although morphine in a dose of 5-10mg is usually adequate there should be no hesitation in increasing it stepwise according to response to 100mg or occasionally up to 500mg or higher if necessary. The BNF comments on the parenteral route 'diamorphine is preferred for injection. The equivalent intramuscular or subcutaneous dose of diamorphine is approximately a third of the oral dose of morphine'
- 8.2 In the chapter on pain relief in 'Drugs and the Older Person' Crome writes on the treatment of acute pain 'treat the underlying cause and give adequate pain relief. The nature of the painful condition, the response of the patient and the presence of comorbidity will dictate whether to start with a mild analgesic or to go immediately to a more potent drug. In order to avoid the situation that patients remain in pain, "starting low" must be followed by regular re-evaluation with, if necessary, frequent increases in drug dose. The usual method of prescribing morphine for chronic pain is to start with standard oral morphine in a

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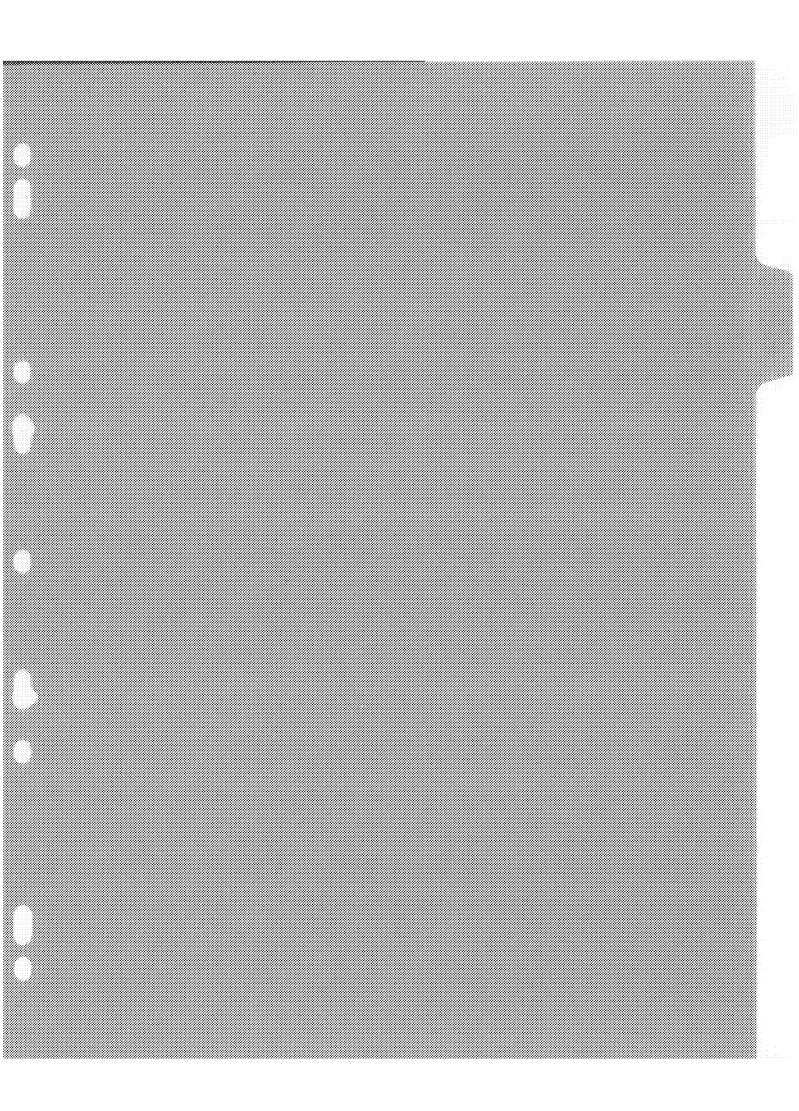
dose of 5-10mg every four hours. The dose should be halved in frail older people.

Prescribing for the Elderly

The British National Formulary states in Prescribing for the Elderly section "The ageing nervous system shows increased susceptibility to many commonly used drugs, such as opioid analgesics, benzodiazepines, antipsychotics and antiparkinsonian drugs, all of which must be used with caution".

APPENDIX 2

BNF Prescribing in palliative care





Portsmouth Road Frimley Camberley Surrey GU16 7UJ

Tel: 01276 604604 Fax: 01276 604148

Elderly Care Unit

Telephone: Code A (direct line)

Fax: Code A (direct into Secretaries' office)

KIM/gnt/gosport

18 October 2001

CONFIDENTIAL

Detective Superintendent J James Hampshire Constabulary Major Incident Complex Kingston Crescent North End PORTSMOUTH PO2 8BU

Dear DS James

CONFIDENTIAL MEDICAL REPORT REGARDING MEDICAL MANAGEMENT
OF PATIENTS AT GOSPORT WAR MEMORIAL HOSPITAL

Thank you for asking me to give a report on the management of four patients who died at Gosport War Memorial Hospital. I have based my personal opinion on my qualification as a specialist in geriatric medicine, my 13 years experience as a Consultant Geriatrician with several years experience working at the local hospice.

USE OF OPIOID ANALGESICS

Opioid analgesics are used to relieve moderate to severe pain and also can be used to relieve distressing breathlessness and cough. The use of pain killing drugs in palliative care (ie the active total care of patients whose disease is not responsive to curative treatment) is described in the British National Formulary which is the standard reference work circulated to all doctors in Great Britain. The guidance in the BNF suggests that non-opioid analgesics such as Aspirin or Paracetamol should be used as first line treatment and occasionally non-steroidal anti-inflammatory drugs may help in the control of bone secondaries. If these drugs are inadequate to control the pain of moderate severity then a weak opioid such as Codeine cr Dextropropoxyphene should be used either alone or in combination with the simple pain killers in adequate dosage. If these weak opioid preparations are not controlling the pain Morphine is the most useful opioid analgesic and is normally given by mouth as an oral solution every 4 hours, starting with a dose between 5 mg and 20 mg, the aim being to choose the lowest dose which prevents pain. The dose should be adjusted with careful assessment of the pain and use of other drugs should also be considered. If the pain is not well controlled the dose should be increased in a step-wise fashion to control the pain.





Sometimes modified release preparations of Morphine are given twice daily once the required dose of Morphine is established, as this may be more convenient for the patient.

If the patient becomes unable to swallow the equivalent intra-muscular dose of Morphine is half the total 24 hour dose given orally. Diamorphine is preferred for injections over Morphine as it is more soluble and can be given in smaller volume, therefore with less distress to the patient.

Subcutaneous infusions of Diamorphine by syringe driver are standard practise if the patient requires repeated intra-muscular injections, to save the patient unnecessary distress. This is standard treatment in Hospices and other medications can be added to deal with anxiety, agitation and nausea as they can safely be mixed with Diamorphine (such as Haloperidol, Cyclizine and Midazolam). The other indications for use of the parenteral route are when the patient is unable to take medicines by mouth due to upper gastro-intestinal problems and occasionally if the patient does not wish to take regular medication by mouth.

The BNF has a table showing the equivalent doses of cral Morphine and parenteral Diamorphine for intramuscular injection or subcutaneous infusion as a guide to the dosage when switching from the cral to the injection route, eg 10 mg of oral Morphine 4 hourly is equivalent to 20 mg of Diamorphine by a subcutaneous infusion every 24 hours, and 100 mg oral Morphine 4 hourly is equivalent to 240 mg of Diamorphine subcutaneously every 24 hours.

SUMMARY

It is clear from the above that a doctor trying to control pain should first start the patient on a non-opioid analgesic, move on to a weak opioid analgesic if the pain is not controlled, consider changing the patient to regular oral Morphine if the pain remains poorly controlled and only start parenteral Diamorphine if the patient is unable (or unwilling) to take Morphine by mouth and would otherwise need regular painful injections of Diamorphine to try and control the pain. There is clear guidance on the dose of Morphine to use in a syringe driver when transferring from oral Morphine to the subcutaneous route. Finally the dose of Morphine or Diamorphine should be reviewed regularly and only increased if the symptom of pain is not adequately controlled.

CASE NOTE REVIEWS

1 ARTHUR CUNNINGHAM

Mr Cunningham was known to suffer with depression, Parkinson's disease and cognitive impairment with poor short term memory. He suffered with long standing low back pain following a spinal injury sustained in the Second World War which required a spinal fusion. He suffered with hypertension and non insulin diabetes mellitus, had a previous right renal stone removed. and bladder stones, and had a previous trans-urethral prostatectomy. Myelodysplasia had been diagnosed (a bone marrow problem affecting the production of the blood constituents). Mr Cunningham had a one month admission under the care of Dr Banks for depression in July and August 1998.

Mr Cunningham was admitted by Dr Lord, Consultant Geriatrician from the Dolphin Day Hospital to Dryad Ward at Gosport War Memorial Hospital on 21 09 1998 because of a large necrotic sacral ulcer with a necrotic area over the left outer aspect of the ankle (these are signs of pressure sores). Dr Lord's intention was to give more aggressive treatment to the sacral ulcer. He was seen by Dr Barton. A dose of 2.5 mg to 10 mg of Oromorph 4 hourly was prescribed and he was given 5 mg prior to his sacral wound dressing at 1450 and a further dose of 10 mg at 2015. Diamorphine via a syringe driver was prescribed at a dose of 20 mg to 200 mg in 24 hours and this was commenced at a dose of 20 mg for 24 hours with Midazolam at 2300 on 21 09 1998. Dr Barton reviewed the patient on 23 September when he was said to be "chesty", Hyoscine was added to the syringe driver and the dose of Midazolam was increased. The patient was noted to be in some discomfort when moved on that day and the next day he was said to be "in pain" and the Diamorphine dose was increased to 40 mg for 24 hours, then 60 mg the following day and 80 mg on the 26 September, there being no further comments as to the patient's condition. The dose of Midazolam and Hyoscine was also increased. The patient died at

<u>Comments</u>

All the prescriptions for opiod analgesia are written in the same hand, and I assume they are Dr Barton's prescriptions although the signature is not decipherable. Morphine was started without any attempts to control the pain with less potent drugs. There was no clear reason why the syringe driver needed to be started as the patient had only received two doses of oral Morphine, the 24 hour dose requirement of Diamorphine could not therefore be established. The dose of Diamorphine prescribed gave a tenfold range from 20 mg to 200 mg in 24 hours which is an unusually large dose range in my experience. The patient was reviewed by Dr Barton on at least one occasion and the patient was noted to be in some discomfort when moved. The dose was therefore appropriately increased to 40 mg per 24 hours but there are no further comments as to why the dose needed to be progressively increased thereafter. In my view Morphine was started prematurely, the switch to a syringe driver was made without any clear reason and the dose was increased without any clear indication.

2 ALICE WILKIE

Miss Wilkie was known to suffer with severe dementia, depression and rectal bleeding attributed to piles. She had been admitted to Philip Ward with a urinary tract infection and immobility under the care of Dr Lord and a decision was made to transfer her to Daedalus ward at Gosport War Memorial Hospital for a few weeks observation prior to a decision on placement. She was transferred on the 6 August and was seen by Dr Peters. The nurses recorded that the patient was complaining of pain but it was difficult to establish the nature or site of this pain. Diamorphine was prescribed on 20 08 1998 in a dose of 20 mg to 200 mg per 24 hours and the signature is identical to that on Mr Cunningham's case which I assume is Dr Barton's. A dose of 30 mg was given on 20 08 1998 with Midazciam and an entry in the notes, again apparently by Dr Barton, comments on a "marked deterioration over last few days". The patient was given another 30 mg of Diamorphine on Code A and died that day at 1830. The patient was said to be comfortable and pain free by the nursing staff on the final day.

<u>Comments</u>

There was no clear indication for an opiod analgesic to be prescribed, and no simple analgesics were given and there was no documented attempt to establish the nature of her pain. In my view the dose of Diamorphine that was prescribed at 30 mg initially was excessive and there is no evidence that the dose was reviewed prior to her death. Again the Diamorphine prescription gave a tenfold range from 20 mg to 200 mg in 24 hours.

3 ROBERT WILSON

Mr Wilson was known to suffer with alcohol abuse with gastritis, hypothyroidism and heart failure. He was originally admitted via Accident & Emergency on the 22 September with a fractured left humerus and transferred to Dickens Ward under the care of Dr Lord. His fracture was managed conservatively. In view of the severe pain he received several doses of Morphine and was prescribed regular Paracetamol.

He was reviewed by Dr Luznat, Consultant Psychogeriatrician, who felt he had an early dementia and depression and recommended an anti-decressant. He was also noted to have poor nutrition.

Dr Lord made a decision to transfer Mr Wiison for a "short spell to a long term NHS bed" with the aim of controlling his pain and presumably to try to rehabilitate him. He was accordingly moved to Dryad ward at Gosport War Memorial Hospital on the 14 October. The transfer letter from Dickens

ward shows that he was still " in a lot of pain in arm".

The prescription appears to have been written by Dr Barton once again. Paracetamol was prescribed but never given by the nursing staff. Oramorph was prescribed 10 mg 4 hourly and 20 mg nocte commencing on 15 10 1998 and the night time dose was given with "good effect" as judged by the nursing staff. The nursing report goes on to say that Mr Wilson had become "chesty" and had "difficulty in swallowing medications". Oramorph was also prescribed 5 mg to 10 mg as required 4 hourly and four doses were given, suggesting Mr Wilson was in persisting pain. on 16 10 1998 the patient was seen by Dr Knapman. The patient was said to be unwell, breathless, unresponsive with gross swelling of the arms and legs. No ECG or oxygen saturation was recorded but the patient's dose of Frusemide (a diuretic) was increased, so I assume the patient was thought to have worsening heart failure. The nurses report a "very bubbly chest". A Diamorphine/Midazolam subcutaneous infusion was prescribed on 16 10 1998 again, in Dr Barton's handwriting, the dose range from 20 mg to 200 mg in 24 hours. 20 mg of Diamorphine was given on 16 10 1998 and the nurses commented later that the "patient appears comfortable", the dose was increased to 40 mg the next day when copious secretions were suctioned from Mr Wilson's chest. On 18 10 1998 the patient was seen by Dr Peters and the dose of Diamorphine was increased to 60 mg in 24 hours and Midazolam and Hyoscine were added. The patient died on Code A at 2340 hours.

Comments

Mr Wilson was clearly in pain from his fractured arm at the time of transfer to Dryad ward. Simple analgesia was prescribed but never given (there was an entry earlier in the episode of care that Mr Wilson had refused Paracetamol). No other analgesia was tried prior to starting morphine. Mr Wilson had difficulty in swallowing medication. The Oramorphine was converted to subcutaneous Diamorphine in appropriate dose as judged by the BNF guidelines. The patient was reviewed by a doctor prior to the final increase in Diamorphine. Once again the Diamorphine prescription had a tenfold dose range as prescribed.

It is clear that Mr Wilson's condition suddenly deteriorated probably due to a combination of worsening heart failure and terminal bronchopneumonia and I consider that the palliative care given was appropriate. A Do Not Resuscitate decision had been made by Dr Lord on 29 09 1998.

4 <u>EVA PAGE</u>

Mrs Page was known to suffer with hypertension, ischaemic heart disease with heart failure and paroxysmal atrial fibrillation, depression, episodic confusion and had sustained a minor stroke in the past. She was admitted on 06 02 1998 to Victory Ward with nausea, anorexia and dehydration and had recently been treated for depression. She was transferred to Charles Ward on 19 02 1998 and had been noted to have a 5 cm mass on chest

x-ray compatible with a lung cancer. She was transferred to Dryad ward, Gosport Memorial Hospital on 27 02 1998 for palliative care. On arrival she was noted to be calling out frequently, and anxious. She was prescribed Thioridazine (a tranquilliser) but this did not relieve her distress and she was prescribed Oramorph 5 mg to 10 mg as required 4 hourly, I believe, by Dr Barton. The nurses report "no relief". She was seen by another doctor who was not named in the nursing record who prescribed regular Thioridazine and Heminevrin at night. On 01 03 1998 it is recorded that Mrs Page "spat out medication", on 02 03 1998 there was an entry, I believe by Dr Barton, stating "no improvement on major tranquillisers. I suggest adequate opioids to control fear and pain". He prescribed a Fentanyl patch 25 mg (another opioid which can be given as a skin patch) and the prescription was countersigned by Dr Lord, I believe. The nursing records state she was "very distressed", she was reviewed by Dr Barton and Diamorphine 5 mg intramuscularly was given. She was then seen by Dr Lord and a further dose of intramuscular 5 mg Diamorphine was given. On 03 03 1998 a syringe driver was started, prescribed, I believe, by Dr Barton, at a dose of 20 mg to 200 mg in 24 hours. The initial dose given was 20 mg of Diamorphine with Midazolam which was started at 1050. The nurses record "rapid deterioration right side flaccid" . The patient died at 2130 Code A

<u>Comments</u>

Mrs Page had a clinical diagnosis of lung cancer. There was no documentation of any symptoms relevant to this and no evidence of metastatic disease. There was no documentation of any pain experienced by the patient. When she was transferred to Dryad Ward most medication was stopped but she required sedative medication because of her distress and anxiety. No psychogeriatric advice was taken regarding her symptom control and she was started on opioid analgesia, in my view, inappropriately. Following her spitting out of medication she was given a topical form of an opioid analgesic (Fentanyl). A decision was taken to start a syringe driver because of her distress. This included Midazolam which would have helped her agitation and anxiety.

The prescription for subcutaneous Diamorphine infusion again showed a tenfold range from 20 mg to 200 mg. It was clear that her physical condition deteriorated rapidly and I suspect she may have had a stroke from the description of the nursing staff shortly prior to death.

CONCLUSIONS

I felt that the nursing records at Gosport War Memorial Hospital were comprehensive on the whole. The reason for starting opioid therapy was not apparent in several of the cases concerned. There had been no mention of any pain, shortness of breath or cough requiring relief. In several of the cases concerned oral morphine was not given for long enough to ascertain the patient's dose requirements, the reason for switching to parenteral Diamorphine via subcutaneous infusion was not documented and the prescription of a tenfold range (20 mg to 200 mg) of

Diamorphine on the "as required" section of the drug chart is, in my view, unacceptable. In my view the dose of Diamorphine should be prescribed on a regular basis and reviewed regularly by medical staff in conjunction with the nursing team. There was little indication why the dose of Diamorphine was increased in several of the cases and the dose appears to have been increased without the input of medical staff on several occasions.

Specimen signatures of Dr Lord and Dr Barton are necessary to confirm the identity of the prescribers and doctors making entries into the clinical notes.

I believe that the use of Diamorphine as described in these four cases suggest that the prescriber did not comply with standard practise. There was no involvement, as far as I could tell, from a palliative care team or specialist nurse advising on pain control. I believe these two issues require further consideration by the Hospital Trust.

i trust this report contains all the essential information you require. Please let me know if you wish me to give any further comment.

Yours sincerely

Code A

DR KIMUNDY FRCP CONSULTANT PHYSICIAN AND GERIATRICIAN

Medical Report: concerning the case of Gladys Mable Richards deceased

Prepared for:

Hampshire Constabulary Major Crime Complex, Fratton Police Station, Kingston Crescent, North End, Portsmouth, Hampshire PO2 8BU

by: Professor Brian Livesley MD FRCP
The University of London's Professor in the Care of the Elderly
Imperial College School of Science, Technology, & Medicine
The Chelsea and Westminster Hospital, London SW10 9NH

For the purpose of ... providing an independent view about treatment given to Mrs Gladys RICHARDS and the factor(s) associated with her death.

Synopsis

- 1. At the age of 91 years, Mrs Gladys RICHARDS was an in-patient in Daedalus ward at Gosport War Memorial Hospital.
- 1.1. A registered medical practitioner prescribed the drugs diamorphine, haloperidol, midazolam, and hyoscine for Mrs Gladys RICHARDS.
- 1.2. These drugs were to be administrated subcutaneously by a syringe driver over an undetermined number of days.
- 1.3. They were given continuously until Mrs RICHARDS became unconscious and died.
- 1.4. During this period there is no evidence that Mrs RICHARDS was given life sustaining fluids or food.
- 1.5. It is my opinion that as a result of being given these drugs, Mrs RICHARDS's death occurred earlier than it would have done from natural causes.

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The writer's declaration

1. This report consisting of thirty-four pages is true to the best of my knowledge and belief and I make it knowing that if tendered in evidence, I shall be liable for prosecution if I have wilfully stated in it anything that I know to be false or do not believe to be true.

Introduction

- 2. The documents with which I have been provided and the visits I have made to the hospitals involved in this enquiry are listed in the Appendix A.
- 2.1. Appendix B contains facts of the environment provided by the statements of Mrs Gillian MACKENZIE (the elder daughter of Mrs Gladys RICHARDS (deceased)) and Mrs Lesley Frances LACK (the younger daughter).
- 2.2. I have indicated any medical terms in **bold type**. I have defined these terms in a glossary in Appendix C.
- 2.3. I have included in Appendix D references to published material.
- 2.4. Appendix E contains details of my qualifications and experience.
- 2.5. This report has been presented on the basis of the information available to me—should additional information become available my opinions and conclusions may be subject to review and modification.

Information relating to Mrs Gladys Richards (deceased)

- Mrs Gladys Mable RICHARDS (née Beech) was born on 13th April 1907 and died on 21st August 1998 aged 91 years.
- 3.1. Mrs Richards has two daughters. They are Mrs Gillian MACKENZIE (the elder daughter) and Mrs Lesley Frances LACK.
 - 3.1.1. Mrs Lack is a retired Registered General Nurse. She retired during 1996 after 41 years continuously in the nursing profession. For 25 years prior to her retirement she was involved in the care of elderly people. For 20 years prior to retirement she held supervisory and managerial positions in this particular field of nursing.
- 3.2. The Glen Heathers Nursing Home is a private registered nursing and residential home at Lee on the Solent, Hampshire. Dr J BASSETT is a general practitioner who visits.

- 3.3. The Royal Hospital Haslar is an acute general hospital in Gosport, Hampshire serviced by the Armed Forces at the time of the incident but available as a National Health Service facility to local people.
- 3.4. Gosport War Memorial Hospital is part of the Portsmouth Healthcare NHS Trust.
 - 3.4.1. Daedalus ward is a continuing care and rehabilitation ward at Gosport War Memorial Hospital.
- 3.5. Dr Jane Ann BARTON is a registered medical practitioner who in 1988 took up a parttime post as clinical assistant in elderly medicine. This post became centered at Gosport War Memorial Hospital. She retired from this part-time post in the year 2000.
- 3.6. Mr Philip James BEED is the clinical manager and charge nurse on Daedalus ward at Gosport War Memorial Hospital. Ms Margaret COUCHMAN and Ms Christine JOICE are registered general nurses who were working on Daedalus ward at the time of the incident.
- 3.7. Dr Anthea Everista Geredith LORD is a consultant physician, within the department of elderly medicine of Portsmouth Healthcare NHS Trust, who was usually responsible for the patients on Daedalus ward and who was on study leave on 17/18 August 1998.
 - 3.7.1. Other consultant physicians from the department of elderly medicine provide on-call consultant physician cover when Dr LORD is absent from duty.

Relevant aspects of Mrs RICHARDS's medical history

- 4. Mrs RICHARDS became resident at the Glen Heathers Nursing Home on 5th August 1994 at the age of 87 years and although disorientated and confused she was able to wash and dress herself and able to go up and down stairs and walk well.
- 4.1. It is noted that she also had a past medical history of bilateral deafness for which she required hearing aids.
 - 4.1.1. Unfortunately both of her hearing aids were lost by December 1997 while she was at the Glen Heathers Nursing Home and had not been replaced by July 1998 when she was admitted to Daedalus ward at Gosport War Memorial Hospital).
 - 4.1.2. It is noted that on 8th July 1998 her general practitioner, Dr J BASSETT wrote to the audiologist at Queen Alexandra Hospital, Cosham requesting an 'URGENT [sic]' domiciliary visit to Glen Heathers Nursing Home. This was '... with a view to supplying her [Mrs RICHARDS] with two new hearing aids.... Since her poor hearing probably contributes to her

confusional state I would be grateful if you would visit with a view to fitting of replacement aids as soon as possible please.'

- 4.2. It is also noted that Mrs RICHARDS had had operations for the removal of cataracts and required glasses.
 - 4.2.1. Unfortunately her spectacles were also lost at the Glen Heathers Nursing Home and had not been replaced by August 1998 when she was admitted to Daedalus ward at Gosport War Memorial Hospital.
 - 4.2.2. As Dr BASSETT had noted Mrs RICHARDS poor hearing probably contributed to her confusional state. The absence of her spectacles would also make it difficult for Mrs RICHARDS to be aware of what was going on around her, further aggravate her confusional state due to lack of sensory stimulation, and increase her dependency on others for her normal daily activities.
 - 4.2.3. The absence of both her hearing aids and her spectacles would make the assessment of and communication with Mrs RICHARDS extremely difficult.
 - 4.2.3.1. It is noted that such sensory deprivation can produce and aggravate confusional and disorientated states.
- 4.3. At the beginning of 1998, she had become increasingly forgetful and less able physically but was inclined to wander and she had about a six months' history of falls.
- 4.4. On 29th July 1998, at the Glen Heathers Nursing Home, Mrs RICHARDS developed a fracture of the neck of her right femur [thighbone] and she was transferred to the Royal Hospital Haslar, Gosport.
 - 4.4.1. In the Accident & Emergency department she was given 2.5mg of morphine and 50 mg of cyclizine at 2300 hours to relieve her pain and distress. She was known to be taking haloperidol 1mg twice daily and Tradazone 100mg at night.
- 4.5. On 30th July 1998 Mrs RICHARDS had a right cemented hemiarthroplasty [an artificial hip joint inserted].
 - 4.5.1. Post-operatively she was given 2.5 mg morphine intravenously on July 30th at 0230 hours, 31st at 0150 and 1905 hours, and on August 1st at 1920 hours and 2nd at 0720 hours. From August 1st -7th she was weaned over to two tablets of **co-codamol**, requiring these on average twice daily for pain relief.
 - 4.5.2. On 3rd August 1998 it was noted 'All well. Sitting out early mobilization'.

- 4.6. On 5th August 1998, Dr REID, a consultant geriatrician, saw her. He stated in a letter that '... she appeared to have a little discomfort on passive movement of the right hip. I understand that she has been sitting out in a chair and I think that, despite her dementia, she should be given the opportunity to try to re-mobilise. I will arrange for her transfer to Gosport Memorial Hospital.'
 - 4.6.1. Dr REID also noted that Mrs RICHARDS had continued on Haloperidol and '... her Trazodone has been omitted. According to her daughters it would seem that since her Tradozone has been omitted she has been much brighter mentally and has been speaking to them at times.'
- 4.7. A discharge letter, dated 10th August 1998, was sent by the sergeant staff nurse at the Royal Hospital Haslar and addressed to 'The Sister in Charge Ward [sic] Memorial Hospital, Bury Road, Gosport, Hants.' It contained the following information:-
 - 4.7.1. After the operation Mrs RICHARDS became '...fully weight bearing, walking with the aid of two nurses and a **Zimmer frame**.' She was noted to require 'total care with washing and dressing, eating and drinking....' She was '... continent, when she become[s] fidgety and agitated it means she wants the toilet....' She 'Occasionally says recognisable words, but not very often.' Her wound 'Is healed, clean and and dry.'
- 4.8. On 11th August 1998, Mrs RICHARDS was transferred to Daedalus ward at the Gosport War Memorial Hospital. She was not in pain and had been fully weight bearing at the Royal Hospital Haslar walking with the aid of two nurses and a Zimmer frame.
 - 4.8.1. At the Gosport War Memorial Hospital there was an unsigned 'Summary' record which is apparently a Nursing record and this states:-
 - 4.8.1.1. '11-8-98 Addmitted [sic] from E6 Ward Royal Hospital Haslar, into a continuing care bed. Gladys had sustained a right fractured neck of Femur on 30th July 1998 in Glen Heathers Nursing Home. She has had a right cemented hemi-arthroplasty and she is now fully weight bearing, walking with the aid of two nurses and a Zimmer frame. Daughter visits regularly and feeds mother. She wishes to be informed Day or night of any deterioration in mothers condition....'
 - 4.8.2. The contiguous 'Assessment Sheet' states, 'Patient has no apparent understanding of her circumstances due to her impaired mental condition ... Deaf in both ears ... Cataract operation to both eyes ... occasionally says recognisable words, but not very often ... soft diet. Enjoys a cup of tea ... requires feeding ... Dental/Oral status Full "Set" keeps teeth in at night.'

- 4.8.3. The 'Patient Medication Information' states, '11.8.98 ... Haloperidol O[rally] 1 mcg [looks like 'mcg' but probably is 'mg' since this drug is not prescribed in single microgram doses] B.D. [twice daily]'
- 4.9. ??[initials]B [subsequently identified as Dr BARTON] has written in the medical case records '11-8-98 Transferred to Daedalus Ward Continuing Care.... O/E [on examination] Impression frail demented lady [paragraph] not obviously in pain [paragraph] Please make comfortable [paragraph] transfers with hoist Usually continent needs help with ADL [activities of daily living].... I am happy for nursing staff to confirm death.'
- 4.10. At 1300 hours on the 13th August 1998 the Nursing Contact Record states 'Found on floor at 13.30hrs [sic]. Checked for injury none apparent at time hoisted into safer chair 20.00 [hours][altered on record to 19.30] pain Rt [right] hip internally rotated. Dr BRIGG contacted advised Xray AM [in the morning] & analgesia during the night. Inappropriate to transfer for Xray this PM [evening] [initialled signature (? by whom)] RGN [Registered General Nurse] [next line] Daughter informed.'
- 4.11 Dr BARTON has recorded '14-8-98 Sedation/pain relief has been a problem screaming not controlled by haloperidol I [illegible symbol or word] but very sensitive to **oramorph**. Fell out of chair last night ... Is this lady well enough for another surgical procedure?'
- 4.12. In her contiguous note Dr BARTON has recorded '14-8-98 Dear [?] Cdr [Commander] SPALDING Further to our telephone conversation thank you for taking this unfortunate lady who slipped from her chair at 1.30 pm yesterday and appears to have dislocated her R[ight] hip.... She has had 2.5ml of 10mg/5ml Oramorph at midday.'
 - 4.12.1. According to the letter signed by Philip BEED, Mrs RICHARDS was given 10mgs of Oramorph at 1150 hours on 14th August 1998 prior to being transferred back to the Royal Hospital Haslar.
- 4.13. The Nursing Contact Record at Daedalus ward continues:-
 - 4.13.1. '14/8/98 am [morning] R[ight] Hip Xrayed Dislocated [paragraph]

 Daughter seen by Dr BARTON & informed of situation. For transfer to
 Haslar A&E [accident and emergency department] for reduction under
 sedation [initialled signature]'
 - 4.13.2. 'pm [afternoon or evening of 14th August 1998] Notified that dislocation has been reduced. [Mrs RICHARDS] To stay in Haslar [hospital] for 48 hours then return to us [[initialled signature] Family aware.'
- 4.14. At the Royal Hospital Haslar (at 1400 hours) Xray having confirmed that the hemiarthroplasty had dislocated, intravenous sedation using 2 mgs of midazolam

allowed the dislocation to be corrected by traction. The procedure was described as 'Under sedation c [with] CVS/RS [cardiovascular and respiratory systems] monitoring. ... Easy reduction.' Mrs RICHARDS was noted to be 'rather unresponsive following the sedation. The [She] gradually became more responsive....' She was then admitted the Royal Hospital for 48 hours observation.

- 4.15. Apart from two tablets of co-codamol on the 15th August 1998, she did not need to be given any pain relief following the reduction of her hip dislocation.
 - 4.15.1. Two days later, on 17th August 1998, it was recorded that 'She was fit for discharge that day and she was to remain in straight knee splint for four weeks. In the discharge letter from Haslar Hospital it was also recorded that Mrs RICHARDS was to return to Daedalus Ward. It was further stated that 'She has been given a canvas immobilising splint to discourage any further dislocation, and this must stay in situ for four weeks. When in bed it is advisable to encourage abduction by using pillows or abduction wedge. She can however mobilise fully weight bearing.'
- 4.16. On 17th August 1998 it was also recorded that she was 'Fit for discharge today (Gos[port] War Mem[orial hospital). To remain in straight knee splint for 4/52 [four weeks] ... No follow-up unless complications.'
- 4.17. She was returned to Daedalus ward in the Gosport War Memorial Hospital later that day but in a very distressed state. The Daedalus ward nursing record states 'Returned from R.N. Haslar, patient very distressed appears to be in pain. No canvas under patient transferred on sheet by crew To remain in straight knee splint for 4/52 [four weeks] For pillow between legs at night (abduction) No follow-up unless complications.'
 - 4.17.1. Mrs RICHARDS was given Oramorph 2.5 mg in 5mls. The nursing record for 17th August 1998 further states '1305 [hours] ... Daughter reports surgeon to say her mother must not be left in pain if dislocation occurs again. Dr Barton contacted and has ordered an Xray. M. COUCHMAN. [paragraph] pm Hip Xrayed at 1545 [hours] Films seen by Dr PETERS & radiologist & no dislocation seen. For pain control overnight & review by Dr BARTON mane [in the morning]. ?[illegible nurse signature]
 - 4.17.1.1. This radiograph was reported by Dr. DOMJAN, Consultant Radiologist as showing 'RIGHT HIP: The right hemiarthroplasty is relocated in the acetabulum.'
- 4.18. On 17th August 1998, Dr BARTON noted 'Readmission to Daedalus from RHH [Royal Hospital Haslar] Closed reduction under iv [intravenous] sedation remained unresponsive for some hours now appears peaceful. Plan Continue haloperidol [paragraph] Only give oramorph if in severe pain See daughter again.'

- 4.19. On 18th August 1998, Dr BARTON recorded 'Still in great pain [paragraph] Nursing a problem. [paragraph] I suggest sc[subcutaneous] diamorphine/Haloperidol/midazolam [paragraph] I will see daughters today [paragraph] please make comfortable.'
- 4.20. The nursing Contact Record on Daedalus ward in the Gosport War Memorial Hospital continues:-
 - 4.20.1. '18/8/98 am Reviewed by Dr Barton. For pain control via syringe driver. [paragraph] 1115 Treatment discussed with both daughters [Mrs LACK and Mrs MACKENZIE]. They agree to use of syringe driver to control pain [It is noted that Mrs LACK has disagreed with this statement] & allow nursing care to be given. [paragraph] 1145 Syringe driver diamorphine 40 mg. Haloperidol 5 mg, Medazolam [midazolam] 20 mg commenced'
 - 4.20.2. '18/8/98 20.00 Patient remained peaceful and sleeping. Reacted to pain when being moved this was pain in both legs. [paragraph] Daughter quite upset and angry about mother's condition, but appears happy that she is pain free at present. C JOICE.'
 - 4.20.2.1. It is noted that a 'disturbance reaction' occurs in patients when they are moved that is easily mistaken for pain requiring specific treatment. It is noted here that Mrs RICHARDS was described as being 'pain free' at this time apart from when she was being moved.
 - 4.20.3. The nursing Contact Record continues 'Daughter, Jill, stayed the night with Gladys [Mrs RICHARDS], grandson arrived in early hours of morning [initialled signature; dated '19/8/98'] [paragraph] He would like to discuss Grand mother's condition with someone either Dr. Barton or Phillip Beed later today [initialled signature]' [paragraph] '19/8/98 am Mrs Richards comfortable. [paragraph] Daughters seen. Unhappy with various aspects of care, complain[t] to be handled officially by Mrs S Hutchings Nursing coordinator [initialled signature]'
 - 4.20.4. It is noted that there is no continuing nursing Contact Record for the 20th August 1998.
 - 4.20.5. The contiguous nursing Contact Record states '21/8/98 12.13 [hours]
 Patient's [Mrs RICHARDS] overall condition deteriorating, medication keeping her comfortable. Daughters visited during the morning. C JOICE'
- 4.21. Dr BARTON's next contiguous medical record was on 21st August 1998 when she wrote 'Much more peaceful [paragraph] needs Hyoscine for rattly chest'.

- 4.21.1. It is noted that Mrs RICHARDS was already being given hyoscine at this time and had been doing so continuously since 19th August 1998.
- 4.21.2. Nurse GRIFFIN made the next note in the medical records on 21st August 1998 stating that Mrs Richards was dead at 2120 hours.
- 4.22. The Nursing Care Plan records state:-
 - 4.22.1. '12.8.98 Requires assistance to settle and sleep at night.... 12.8.98 Haloperidol given at 2330 [hours] as woke from sleep very agitated shaking and crying. Didn't settle for more than a few minutes at a time. Did not seem to be in pain.'
 - 4.22.2. '13.8.98 oromorph at 2100 [hours] Slept well [initialled signature] [paragraph] For Xray tomorrow morning [initialled signature]'
 - 4.22.3. '14.8.98 Same pain in rt[right] leg / ?[query] hip this am. [initialled signature]'
 - 4.22.4. 'Re-admitted 17/8/98'
 - 4.22.5. '17.8.98 Oromorph [Oramorph] 10mg/5ml at present.'
 - 4.22.6. '18.8.98 Now has a syringe driver with 40mgs Diamorphine comfortable. Daughters stayed. [initialled signature]'
 - 4.22.7. 'Daughters stayed with Gladys [Mrs RICHARDS] overnight. [initialled signature]'
 - 4.22.8. There is no record of continuance of the Nursing Care Plan for 20th and 21st August 1998.
 - 4.22.9. After Mrs RICHARDS had been readmitted to Daedalus ward on 17th August 1998, there is no record between 17th and 21st August 1998 in the patient Nursing Care Plan for 'Nutrition'. On 21st August the record states 'no food taken [initialled signature]'.
 - 4.22.9.1. There is no record that Mrs RICHARDS was offered any fluids.
 - 4.22.10. Similarly, the Nursing Care Plan for 'Constipation' shows no record between 17th and 21st August 1998. On 21st August the record states 'BNO [bowels not open] [initialled signature]'
 - 4.22.11. The Nursing Care Plan for 'Personal Hygiene' states:-

- 4.22.11.1. '18.8.98 Complete Bed Bath given plus oral [Signature] Hygiene [second signature]'
- 4.22.11.2. '18.8.98 Night: oral care given frequently'
- 4.22.11.3. '19.8.98 Nightie changed & washed, repositioned. Apparently pain free during care [initialled signature]'
- 4.22.11.4. It is noted that there is no record of Mrs Richards being attended to for 'Personal Hygiene' on 20th August 1998.
- 4.22.11.5. '21.9.98 General care and oral hygiene given [initialled signature]'
- 4.23. The drugs prescribed for Mrs RICHARDS at Gosport War Memorial Hospital from the time of her admission there on 11th August 1998 are described below.

Drugs prescribed for Mrs RICHARDS at Gosport War Memorial Hospital

- 5. Dr BARTON wrote the following drug prescriptions for Mrs RICHARDS.
- 5.1. On 11th August 1998:-
 - 5.1.1. Oramorph 10mgs in 5mls to be given orally four hourly. On the Administration Record these doses are recorded as being given—
 - 5.1.1.1. twice on 11th August 1998 (10mg at 1015 [?1215] and 10mg at 1145 [?pm]);
 - 5.1.1.2. once on 12th August (10mg at 0615);
 - 5.1.1.3. once on 13th August (10mg at 2050);
 - 5.1.1.4. once on 14th August (5ml [10mg] at 1150);
 - 5.1.1.5. four times on 17th August (2.5ml [5mg] at 1300, 2.5ml [5mg] at ?????[time illegible], 2.5ml [5mg] at1645, and 5ml [10mg] at 2030); and,
 - 5.1.1.6. twice on 18th August 1998 5ml [10mg] at 01230[sic and? meaning 0030 hours] and 5ml [10mg] at [?]0415).
 - 5.1.2. Diamorphine at a dose range of 20 200 mg to be given subcutaneously in 24 hours.

- 5.1.2.1. None of this diamorphine prescription is recorded on the Administration Record as having been given between $11^{th} 14^{th}$ August inclusive.
- 5.1.3. Hyoscine at a dose range of 200 800 mcg [micrograms] to be given subcutaneously in 24 hours.
 - 5.1.3.1. None of this hyoscine prescription is recorded on the Administration Record as having been given between $11^{th} 14^{th}$ August inclusive.
- 5.1.4. Midazolam at a dose range of 20-80 mgs to be given subcutaneously in 24 hours.
 - 5.1.4.1. None of this midazolam prescription is recorded on the Administration Record as having been given between 11th 14th August inclusive.
- 5.1.5. Haloperidol 1mg orally twice daily. It is noted that at the top of this prescription chart 'TAKES MEDICINE OFF A SPOON' [sic] is clearly written.
 - 5.1.5.1. She was give 1mg of haloperidol at 1800 hours on 11th August 1998, at 0800 and 2330 hours on 12th August 1998, at 0800 and 1800 hours on 13th August 1998.
 - 5.1.5.2. In addition, on 13th August 1998, Mrs RICHARDS was prescribed haloperidol 2mgs in 1ml to be administered orally as required at a dose of 2.5ml [this figure has been altered and also can be read as 0.5 ml] to be given 'IF NOISY' [sic]. She was given a dose [quantity not stated bearing in mind the altered prescription] at 1300 on 13th August 1998.
 - 5.1.5.3. She was also given 1mg of haloperidol at 0800 hours on 14th and also at 1800 hours on 17 August 1998.
- 5.1.6. It is noted that, apart from 2330 hours on 12 August 1998, at the above times when Mrs RICHARDS was given haloperidol she was also give 10ml of Lactulose [a purgative].
- 5.2. On 12th August 1998:-
 - 5.2.1. Oramorph 10mgs in 5mls to be given orally in a dose of 2.5 mls four hourly [equivalent to 5mgs of oramorph].

- 5.2.1.1. Although this drug was apparently not administered its prescription was written up on the 'Regular Prescription' chart but at the side in an ink-drawn box there are the letters PRN [meaning that the prescription is to be administered as required].
- 5.2.2. Oramorph 10mgs in 5mls to be given orally once at night.
 - 5.2.2.1. Although this drug was apparently not administered its prescription was also written up on the 'Regular Prescription' chart but at the side in an ink-drawn box there are the letters PRN [meaning that the prescription is to be administered as required].
- 5.3. 18th August 1998:-
 - 5.3.1. Diamorphine at a dose range of 40-200mg to be administered subcutaneously in 24 hours
 - 5.3.2. Haloperidol a dose range of 5-10 mgs to be administered subcutaneously in 24 hours.
- 5.4. On 18th, 19th, 20th, and 21st August 1998, Mrs RICHARDS was given simultaneously and continuously subcutaneously diamorphine 40mgs, and haloperidol 5mgs, and midazolam 20mgs during each 24 hours.
 - 5.4.1. These drugs are recorded as being administered at the same time of day on each of the four days they were given. They were administered at 1145, 1120, 1045, and 1155 for 18th, 19th, 20th, and 21st August 1998 respectively.
 - 5.4.1.1. All these drugs were administered at the times stated and were signed off by initials as being co-administered by the same person each day. Over the four days of 18th, 19th, 20th, and 21st August 1998, at least three nurses were involved in administering these drugs.
 - 5.4.1.2. According to the prescription charts these drugs were signed for as being administered to Mrs RICHARDS via the syringe driver by Mr Philip BEED on 18th and 19th August 1998, by Ms Margaret COUCHMAN on 20th August 1998, and by Ms Christine JOICE on 21st August 1998.
 - 5.4.2. It is noted that on the 19th, 20th, and 21st August 1998 the drugs midazolam 20mgs, diamorphine 40mgs, and haloperidol 5mgs were also co-administered subcutaneously in 24 hours with 400mcg of hyoscine [this last drug had been

- prescribed by Dr BARTON to be given as required on 11th August 1998 but its administration was not commenced until 19th August 1998].
- 5.4.3. It is also noted that all the drugs for subcutaneous administration were not prescribed at specific starting dosages but each was prescribed for a wide range of dosages and for continuous administration over 24-hour periods.
 - 5.4.3.1. It is not known who selected the dosages to be given.

Death certification and cremation

- 6. The circumstances of Mrs RICHARDS death have been recorded as follows:
- 6.1. In a document [Case no. 1630/98] initialled by the Coroner on 24th August 1998 'Reported by Dr BARTON [sic]. Deceased had undergone surgery for a fractured neck of femur. Repaired. Death cert[ificate] issued. [paragraph] THOMAS [sic]
- 6.2. The cause of death was accepted by the Coroner on 24th August 1998 as being due to:-
 - 6.2.1. '1(a) Bronchopneumonia'.
 - 6.2.2. The death was certified as such by Dr J A BARTON and registered on 24th August 1998.
 - 6.2.3. It is noted that the continuous subcutaneous administration of diamorphine, haloperidol, midazolam, and hyoscine to an elderly person can produce unconsciousness and death from respiratory failure associated with pneumonia.
- 6.3. The body was cremated.

Conclusions

- 7. Mrs Gladys Mable RICHARDS died on 21st August 1998 while receiving treatment on Daedalus ward at Gosport War Memorial Hospital.
- 7.1. Some fours years earlier, on 5th August 1994, Mrs RICHARDS had become resident at the Glen Heathers Nursing Home.
- 7.2. Mrs RICHARDS's had a confused state that after December 1997 had been aggravated by the loss at the Glen Heathers Nursing Home of her spectacles and both of her hearing aids.

- 7.3. On 29th July 1998, Mrs RICHARDS developed a fracture of the neck of her right femur [thighbone] and she was transferred from the Glen Heathers Nursing Home to the Royal Hospital Haslar, Gosport.
- 7.4. Despite her confused state, Mrs RICHARDS was considered by medical staff at the Royal Hospital Haslar to be suitable for implantation of an artificial hip joint. This took place on 30th July 1998.
- 7.5. On 11th August 1998, and having been seen by a consultant geriatrician, Mrs RICHARDS was transferred for rehabilitation to Daedalus ward at Gosport War Memorial Hospital.
- 7.6. At that time Dr BARTON recorded that Mrs RICHARDS was not obviously in pain but despite this Dr BARTON prescribed Oramorph [an oral morphine preparation] to be administered orally four hourly.
 - 7.6.1. At that time also Dr BARTON prescribed for Mrs RICHARDS diamorphine, hyoscine, and midazolam. These drugs were to be given subcutaneously and continuously over periods of 24 hours for an undetermined number of days and the exact dosages were to be selected from wide dose ranges.
 - 7.6.2. Also on 11th August 1998, at the end of a short case note, Dr BARTON wrote 'I am happy for nursing staff to confirm death'.
 - 7.6.3. It is noted that although prescribed on the day of her admission to Daedalus ward at Gosport War Memorial Hospital these drugs (diamorphine, hyoscine, and midazolam) were not administered at that time.
- 7.7. On 13th August 1998, Mrs RICHARDS's artificial hip joint became dislocated.
- 7.8. The following day, 14th August 1998, although Dr BARTON had recorded 'Is this lady well enough for another surgical procedure?' she arranged for Mrs RICHARDS to be transferred back to Haslar Hospital where the dislocation of the hip was reduced.
 - 7.8.1. It is noted that at the age of 91 years, and despite Dr Barton's comment about Mrs RICHARDS, and her confused mental state, Mrs RICHARDS was considered well enough by the staff at the Royal Hospital Haslar to have two operations on her right hip within about two weeks.
- 7.9. Three days later, on 17th August 1998, Mrs RICHARDS was returned to the Gosport War Memorial Hospital on a sheet and not on a stretcher. She was very distressed when she reached Daedalus ward.

- 7.10. There is no evidence that Mrs RICHARDS, although in pain, had any specific life-threatening and terminal illness that was not amenable to treatment and from which she could not be expected to recover.
- 7.11. Despite this, and on 18th August 1998, Dr BARTON, while knowing of Mrs RICHARDS's sensitivity to oral morphine and midazolam, prescribed diamorphine, midazolam, haloperidol, and hyoscine to be given (from wide dosages ranges) continuously subcutaneously and by a syringe driver over periods of 24 hours for an unlimited period.
 - 7.11.1. Neither midazolam nor haloperidol is licensed for subcutaneous administration.
 - 7.11.2. It is noted, however, that in clinical practice these drugs are administered subcutaneously in the management of distressing symptoms during end-of-life care for cancer.
 - 7.11.3. It is also noted that Mrs RICHARDS was not receiving treatment for cancer.
- 7.12. There is no evidence that in fulfilling her duty of care Dr BARTON reviewed appropriately Mrs RICHARDS's clinical condition from 18th August 1998 to determine if any reduction in the drug treatment being given was indicated.
- 7.13. 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 in any appropriate manner.
- 7.14. There is no evidence that in fulfilling their duty of care Mr Philip BEED, Ms Margaret COUCHMAN and Ms Christine JOICE reviewed appropriately Mrs RICHARDS's clinical condition from 18th August 1998 to determine if any reduction in the drug treatment they were administering was indicated.
- 7.15. There is, however, indisputable evidence that the subcutaneous administration of drugs by syringe driver continued without modification and during every 24 hours from 18th August 1998 until Mrs RICHARDS died on 21st August 1998.
- 7.16. Dr Barton recorded that death was due to bronchopneumonia.
 - 7.16.1. It is noted that the continuous subcutaneous administration of diamorphine, haloperidol, midazolam, and hyoscine to an elderly person can produce unconsciousness and death from respiratory failure associated with pneumonia.

My opinion

- 8. When Mrs RICHARDS was first admitted to Daedalus ward at Gosport War Memorial hospital on 11th August 1998 she was not in pain and had been fully weight bearing walking with the aid of two nurses and a Zimmer frame.
- 8.1. Despite recording that Mrs RICHARDS was not in pain, on 11th August 1998 Dr BARTON prescribed wide dosage ranges of opiate and sedative drugs to which Mrs RICHARDS was known to be sensitive.
 - 8.1.1. Dr Barton also recorded that 'I am happy for nursing staff to confirm death.' when Mrs RICHARDS had been admitted for rehabilitation and her death was not obviously imminent.
- 8.2. When, at the age of 91 years, Mrs RICHARDS dislocated her operated hip and despite her confused mental state, she was considered well enough to have a second operation on her right hip within about two weeks of the first operation.
- 8.3. There is no evidence to show that after her second operation Mrs RICHARDS, although in pain, had any specific life-threatening and terminal illness that was not amenable to treatment and from which she could not be expected to recover.
- 8.4. It is my opinion, and there is evidence to show, that Mrs RICHARDS was capable of receiving oral medication for the relief of the pain she was experiencing on 17th August 1998.
- 8.5. Mrs RICHARDS was known by Dr BARTON to be very sensitive to Oramorph, an oral morphine preparation, and to have had a prolonged sedated response to intravenous midazolam.
- 8.6. Despite this, and from 18th August 1998 for an undetermined and unlimited number of days, Dr BARTON prescription led over 24-hours periods to the continuous subcutaneous administration to Mrs RICHARDS of diamorphine 40mgs, haloperidol 5mgs, and midazolam 20mgs to which was added hyoscine 400mcg from 19th August 1998.
- 8.7. The administration of these drugs continued on a 24-hours regime without their dosages being modified according to Mrs RICHARDS's response to them and until Mrs RICHARDS died on 21st August 1998.
- 8.8. There is no record that Mrs RICHARDS was given any food or fluids to sustain her from the 18th August 1998 until she died on 21st August 1998.

- 8.9. As a result of the continuous subcutaneous administration of the prescribed drugs diamorphine, haloperidol, midazolam, and hyoscine Mrs RICHARDS became unconsciousness and died on Code A
- 8.10. No other event occurred to break the chain of causation and in my opinion Mrs RICHARDS's death was directly attributable to the administration of the drugs she continuously received by syringe driver from 18th August 1998 until her death on Code A
- 8.11. It is my opinion that Mrs Gladys RICHARDS's death occurred earlier than it would have done from natural causes and was the result of the continuous administration of diamorphine, haloperidol, midazolam, and hyoscine which had been prescribed to be administered continuously by a syringe driver for an undetermined number of days.

APPENDIX A

- 14. I have received and read the following documents:-
- 14.1. The letter of DCI BURT dated 22nd November 1999 that gave an initial overview of the case.
- 14.2. The documents in the file DCI BURT presented at our meeting on 28th January 2000 as follows:-
 - 14.2.1. 1) Draft (unsigned) statement (MG11) of Lesley HUMPHREY.
 - 14.2.2. 2) Copy of PEC (NHS) T Health Record (LH/1/C).
 - 14.2.3. 3) Copy of RHH Medical Record (AF/1/C).
 - 14.2.4. 4) Draft (unsigned) statement (MG11) of Gillian MACKENZ1E.
 - 14.2.5. 5) Draft (unsigned) statement of Lesley LACK.
- 14.3. The documents in the file DCI BURT presented at our meeting on 8th March 2000 including those pursuant to my request of 28th January 2000 (documents WX1, WX2, and YZ were forward to me on 9 March 2000) as follows:-
 - 14.3.1. A Typed copy of Notes prepared by Mrs LACK and given to Portsmouth Healthcare NHS Trust
 - 14.3.2. B Typed copy of additional page of notes which was prepared by Mrs LACK but, apparently, not passed to Portsmouth Healthcare NHS Trust
 - 14.3.3. C Typed copy of Notes prepared by Mrs LACK and given to Social Services
 - 14.3.4. D Typed copy of comments made by Mrs LACK in respect of letter from Portsmouth Healthcare NHS Trust which represented a response to her Notes of complaint (A)

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14.3.5.	Ε	Typed copy of comments made by Mrs LACK in respect of a Report
		prepared by Portsmouth Healthcare NHS Trust which resulted in
		the letter referred to above
14.3.6.	F	As D above but made by Mrs MACKENZIE
14.3.7.	G	As E above but made by Mrs MACKENZIE
14.3.8.	HI	Copy of letter written by Mrs MACKENZIE to DI MORGAN (OIC
		of initial investigation) plus 5 copies newspaper cuttings
14.3.9.	JК	Copy of Coroner's Officer's Form
14.3.10.	L	Copy of letter from Dr REID to S/Cdr SCOTT
14.3.11.	M	Copy of Report made by Dr LORD during original investigation
14.3.12.	N	Copy of additional newspaper cutting
14.3.13.	O(1)	
14.3.14.	O (2)	
		(Portsmouth Healthcare NHS Trust)
14.3.15.	O (3)	Copy of signed statement of Lesley LACK
14.3.16.	O (4)	
14.3.17.	PQ	Copy of schedule of x-ray images (RHH)
14.3.18.	R	Copy of Risk Event Record (Portsmouth Healthcare NHS Trust)
14.3.19.	S (1)	Copy of letter which DCI BURT has sent to Lesley HUMPHREY
		(Portsmouth Healthcare NHS Trust) raising various issues
14.3.20.	S (2)	Copy of entries in medical directories 1998/1999 - Dr Jane Ann BARTON
14.3.21.	S (3)	Copy of letter from Mrs MACKENZIE to DCI BURT
14,3,22.	S (4)	Copy of documents which accompanied the two Portsmouth
		Healthcare NHS Trust x-ray images
14.3.23.	T	Copy of various documents which featured in a Social Services Case
		Conference stemming from receipt of Mrs LACK's Notes of
		complaint (C above)
14.3.24.	UV	Copy of Death Certificate - Mrs RICHARDS
14.3.25.	WX1	Witness Statement of Mrs Gillian MACKENZIE dated March 6
		2000
14.3.26.	WX2	Copy of letter from DR J.H. BASSETT to Mrs MACKENZIE with
		an addendum of five pages being a photocopy from 'Toxic
		Psychiatry' a book by Dr Peter BREGGEN published by Harper
		Collins.
14.3.27.	YZ	Two extracts from 'Criminal Law. Diana Rowe. Hodder &
		Stoughton 1999.'

- 14.4. On 8th March 2000, in the presence of DCI BURT, I visited:-
 - 14.4.1. the Gosport Memorial Hospital and followed the passageways along which Mrs Richards was conveyed and the ward areas in which she was treated; and,
 - 14.4.2. the Royal Hospital Haslar and followed the passageways along which Mrs Richards was conveyed and the ward area in which she was treated.

- 14.4.2.1. At the Royal Hospital Haslar, on 8th March 2000, in the presence of DCI BURT, I was also shown twelve (12) radiographs relating to Mrs Richards' treatment there on 12th April 1998, 17th July 1998, 14th August 1998, 29th July 1998, and 31st July 1998.
- 14.5. In addition I have read the following the documents given to me by DCI BURT on 12th May 2000 consisting of the following which are numbered below as listed in the two containing ring binders:
 - 14.5.1. E 25 Copy of Glen Care Homes file Re: Gladys RICHARDS supplied by Glen Care Homes
 - 14.5.2. E 22 Copy of Hampshire County Council Social Services file Re: Gladys RICHARDS
 - 14.5.3. E23 Copy of Glen Care Homes file Re: Gladys RICHARDS supplied
 Nursing Homes Inspectorate
 - 14.5.4. E 24 Copy Portsmouth and South East Hampshire Health Authority GP Patient Records of Gladys RICHARDS
 - 14.5.5. D 63 Police letter 090300 to Miss CROSS, Haslar Hospital with further questions
 - 14.5.6. D 65 Letter 100400 from Miss CROSS at Haslar including Patient transfer order and further medical records
 - 14.5.7. D 104 Letter 080200 from Mrs. MACKENZIE with notes Re: draft statement
 - 14.5.8. D 108 Portsmouth NHS Trust Dept. of Diagnostic Imaging report folder
 - 14.5.9. D 110 Copy typed Gladys RICHARDS Death Certificate dated 240898
- 14.6. I have also read the documents given to me by DCI BURT on 19th July 2000, consisting of copies of the statements made by:-
 - 14.6.1. JOICE Christine
 - 14.6.2. GIFFIN Sylvia Roberta
 - 14.6.3. PULFORD Monica Catherine
 - 14.6.4. WALKER Fiona Lorraine
 - 14.6.5. MARJORAM Catherine
 - 14.6.6. BALDACCHINO Linda Mary
 - 14.6.7. PERKINS Margaret Joan
 - 14.6.8. TUBBRITT Anita
 - 14.6.9. COUCHMAN Margaret
 - 14.6.10. WALLINGTON Kathleen Mary
 - 14.6.11. FLETCHER Anne
 - 14.6.12. COOK Joanne
 - 14.6.13. MOSS JEAN Kathleen
 - 14.6.14. TYLER Christina Ann

- 14.7. I have also read statements, provided on 30th August 2000 by DCI BURT, made by:
 - 14.7.1. Doctor Jane Ann BARTON
 - 14.7.2. Phillip James BEED
- 14.8. I have also received from DCI BURT on 8th September 2000 and read copies of:-
 - 14.8.1. A letter dated 18th August 2000 from Mrs Gillian MACKENZIE to DCI BURT.
 - 14.8.1.1. Enclosed with this letter was a copy of a letter dated 9th August 2000 from Ms Jill BAKER to Mrs Gillian MACKENZIE to which had been added a petition form.
- 14.9. A letter dated 21st August 2000 from Mrs Gillian MACKENZIE to DCI BURT.
 - 14.9.1. Enclosed with this letter was a copy of a letter dated 14th December 1998 from Ms Lesley HUMPHREY, Quality Manager at Portsmouth Healthcare NHS Trust Central Office to Mrs Gillian MACKENZIE. This had enclosed with it a copy of a letter dated 22nd September 1998 from Mr Max MILLETT, Chief Executive of Portsmouth Healthcare NHS Trust.
- 14.10. Copies of Witness Statements (taken by Mrs S HUTCHINGS who led the initial Internal Inquiry as Investigating Officer of Portsmouth Healthcare NHS Trust) as follows:-
 - 14.10.1. On 3rd September 1998 statement consisting of four pages from Mrs Jenny BREWER Staff Nurse Daedalus Ward to which is attached an additional statement (three pages) by Staff Nurse Brewer (the first page of this three pages is headed Portsmouth Healthcare NHS Trust and has been signed on page three by S. N J Brewer RGN and dated 9-9-98 (Reference D142)).
 - 14.10.2. On 8th September 1998 statement consisting of five pages from Mr Philip BEED Clinical Manager Daedalus Ward (Reference D143).
 - 14.10.3. On 9th September 1998 statement consisting of three pages from Ms
 Christine JOICE Staff Nurse Daedalus Ward (Reference D144).
 - 14.10.4. On 8th September 1998 statement consisting of two pages from Ms Monica PULFORD Enrolled Nurse Daedalus Ward (Reference D145).
 - 14.10.5. On 3rd September 1998 statement consisting of four pages from Ms Margaret COUCHMAN Staff Nurse Daedalus Ward (Reference D146).

- 14.11. A copy of the National Council for Hospice and Specialist Palliative Care Services paper entitled 'Ethical decision-making in palliative care'.
- 14.12. On 5th and 6th October 2000 I received from Hampshire Constabulary and subsequently read:-
 - 14.12.1. The records of the interviews conducted with Dr Anthea Everista Geredith LORD on 27th September 2000.
 - 14.12.2. During these interviews Dr LORD produced as listed in the Officer's Report by DC McNally the following documents:-
 - 14.12.2.1. Drug Therapy Guidelines for subcutaneous fluid replacement as approved by the Elderly Medicine and Formulary & Medicines Group of Portsmouth Hospitals and Portsmouth Healthcare updated for 1998.
 - 14.12.2.2. Consultants' Rota for August 1998 of the Department of Medicine for Elderly People (Ref: CI/28.7.98).
 - 14.12.2.3. Memorandum from Mrs. L HUMPHREY of Portsmouth Health Care NHS Trust to Dr. LORD dated 17th December 1998 and headed 'Mrs. Richards deceased, Gosport War Memorial Hospital, Code A
 - 14.12.2.4. Letter from Dr R I REID, Medical Director of Portsmouth Health Care NHS Trust giving approval of study leave for Dr. LORD for the dates of 17/18 August 1998.
 - 14.12.2.5. Consultants' Timetable of the Department of Medicine for Elderly People from 4.5.98 8.2.99.

Appendix B

Facts of the environment - obtained from the statements of Mrs RICHARDS's daughters

- 15. Mrs MACKENZIE is the elder of Mrs RICHARDS's two daughters. It is noted that her sister, Mrs LACK, is a retired Registered General Nurse.
- 15.1. Mrs LACK retired in 1996 after 41 years continuously in the nursing profession. For 25 years prior to retirement she was involved in the care of elderly people. For 20 years prior to retiring she held supervisory and managerial positions in this field of nursing.

- 15.2. By July 1998, Mrs RICHARDS had been resident at the Glen Heathers Nursing Home for some four years. She had a past medical history of bilateral deafness for which she required two hearing aids (unfortunately these were lost while she was at the Glen Heathers Nursing Home). She had had operations for the removal of cataracts and required glasses (unfortunately these were also lost at the Glen Heathers Nursing Home).
- 15.3. Also by July 1998, Mrs RICHARDS had become increasingly forgetful and less able physically. She had had 17 falls documented at the Glen Heathers Nursing Home between 29th January 1998 and 29th July 1998.
 - 15.3.1. During this period Mrs MACKENZIE decided to meet and question her mother's general practitioner, Dr BASSETT. Mrs MACKENZIE had formed the opinion that the drugs Dr BASSETT was prescribing could contribute to her mother's confused mental state and deterioration of her physical health. One drug was Trazodone and the other was haloperidol. Following this meeting she sent him a copy of a book entitled *Toxic Psychiatry*.
 - 15.3.2. Dr BASSETT replied, in a hand-written letter, thanking Mrs MACKENZIE and stating '... I have a reputation in Lee [-on-Solent] of being somewhat sparing with 'mood' drugs and especially antibiotics. ... most drugs are prescribed with more caution these days. [paragraph] Hopefully we can continue to keep your Mother's drugs to a minimum!'
- 15.4. It is convenient to mention here that both Mrs MACKENZIE and Mrs LACK have registered serious concerns about the care given to their mother in the Glen Heathers Nursing Home.
 - 15.4.1. Jane PAGE, Principal Nursing Home Inspector, Portsmouth & S.E. Hants Health Authority investigated these concerns formally. On 11th August 1998, she made an unannounced visit to the Glen Heathers Nursing Home. She reported, on 26th August 1998, that 'From the written records obtained and discussions held, I can find no evidence to substantiate that Mrs RICHARDS did not receive appropriate care and medication.'
 - 15.4.2. These concerns were discussed further by the Social Services Department at a meeting held on 23rd November 1998 when Mrs LACK was present. The conclusion was that 'There was no evidence of deliberate abuse [of Mrs RICHARDS] although there seemed to be problems of complacency in some of the care practices which needed review.... However, there was no evidence of malpractice by the Home.'
- 15.5. On 29th July 1998, while in the Glen Heathers Nursing Home, Mrs RICHARDS sustained a fracture of the neck of her right femur (thighbone). According to Mrs

LACK her mother underwent a surgical operation on 30th July 1998 'following a discussion with the consultant who thought my mother should be given the chance to remain ambulant.'

15.6. Mrs LACK has also stated:-

- 15.6.1. 'My mother received a replacement hip, on her right side, and remained in the Haslar Hospital a further eleven days until Tuesday the 11th August 1998. [paragraph] I visited my mother every day during this period and, in my view, when taking into account the serious injury which she had sustained and the trauma she had suffered, my mother appeared to make a good recovery during this period.'
- 15.6.2. 'Prior to her discharge, and transfer to the Gosport War Memorial Hospital, my mother was responding to physiotherapy, able to walk a short distance with the aid of a zimmer frame and no longer required a catheter. Her medication had been reduced and she was able to recognise family members and make comments to us which made sense.'
- 15.6.3. 'She was with encouragement, eating and drinking naturally and as a result the drips, which had facilitated the provision of nourishment after the operation, had been removed.'
- 15.6.4. Significantly, my mother was no longer in need of pain relief. It was quite apparent, to me, that she was free of pain.
- 15.6.5. Such was the extent of my mother's recovery that it was considered appropriate to discharge her and transfer her to the Gosport War Memorial Hospital where she was admitted to Daedalus Ward on Tuesday the 11th August 1998. This was the first occasion that my mother had been admitted to this particular hospital.'
- 15.7. On 12th August 1998, the day after her mother's admission to the Gosport War Memorial Hospital, Mrs LACK visited her mother there and has recorded '... I was rather surprised to discover that I could not rouse her [Mrs RICHARDS]. As she was unrousable she could not take nourishment or be kept hydrated. [paragraph] I enquired among the staff and I was told that my mother had been given the morphine based drug 'Oramorph' for pain. This also surprised me. When my mother had been discharged from the Haslar Hospital, the day before, she had not required pain relief for several days. [paragraph] I was distressed to observe my mother's deteriorated condition which significantly contrasted with the level of recovery which had been achieved following treatment at the Haslar hospital during the period after the surgical operation to replace her hip. [paragraph] I was told that my mother had been calling out, showing signs of being anxious, and it was believed that she was suffering pain. They did not investigate the possible cause. I consider it likely that she was in need of the toilet. ... One of the

- consequences of being rendered unrousable, by the effects of 'Oramorph', was that no fluids could be given to my mother and this, together with the abandonment of other forms of rehabilitation, would have served to inhibit or prevent the recovery process which had begun prior to her admission to the Gosport War Memorial Hospital.'
- 15.8. Mrs RICHARDS had a fall on 13th August 1998 (as described above). On the following morning (14th August 1998), Mrs LACK noted that while her mother was being taken to the X-ray department at the Gosport War Memorial Hospital 'She was still deeply under the effects of the 'Oramorph' drug.'
- 15.9. As described above Mrs RICHARDS was then transferred to the Royal Hospital Haslar for the reduction of her dislocated artificial hip. She was returned to the Gosport War Memorial Hospital on 17th August 1998 having been noted the previous day (16th August) by Mrs LACK [a nurse experienced in the care of elderly people] to be 'easily manageable'.
 - 15.9.1. In accepting that he would transfer Mrs RICHARDS to the Gosport War Memorial Hospital, Dr REID (consultant geriatrician) had stated that '... despite her dementia, she [Mrs RICHARDS] should be given the opportunity to try to re-mobilise.'
- 15.10. On visiting her mother at the Gosport War Memorial Hospital at about 1215 hours on 17th August 1998, Mrs LACK accompanied by her sister [Mrs MACKENZIE], found her mother to be screaming and in pain. The screaming ceased 'within minutes' when Mrs LACK and a registered general nurse repositioned Mrs Richards.
- 15.11. Subsequently, the X-ray at the Gosport War Memorial Hospital showed no fresh dislocation of the artificial hip.
- 15.12. Following this further X-ray, Mrs LACK told Dr BARTON that Haslar Hospital would be prepared to readmit her mother. Dr BARTON is reported to have '... felt that was inappropriate.' Mrs LACK '... considered this was essential so that the 'cause' of my mother's pain could be treated and not simply the pain itself.'
 - 15.12.1. Dr BARTON is stated to have said to Mrs LACK that, '... "It was not appropriate for a 91 year old, who had been through two operations, to go back to Haslar Hospital where she would not survive further surgery."
- 15.13. Mrs LACK states that, on 18th August 1998, the Ward Manager [Mr Philip BEED] explained to her and her sister that a syringe driver was going to be used. This was to ensure Mrs RICHARDS 'was pain free at all times' so that she would not suffer when washed, moved, or changed in the event she should become incontinent. Mrs LACK has also described in her contemporaneous notes (as well as in her Witness Statement, see below) that 'A little later Dr BARTON appeared and confirmed that a haematoma

was present and that this [the use of a syringe driver] was the kindest way to treat my mother. She [Dr BARTON] also stated "And the next thing will be a chest infection."

In her Witness Statement, Mrs LACK has recorded 'The outcome of the syringe driver was explained to my sister and I fully. Drawing on my experience as a nurse I [Mrs LACK] knew that the continuous use of morphine, as means of relieving her pain, could result in her death. She [Mrs. RICHARDS] was, at the time, unconscious from the effects of previous doses of 'Oramorph'.... [paragraph] As result of seeing my mother in such great pain I was becoming quite distressed at this stage. My sister asked the Ward Manager, "Are we talking about euthanasia? It's illegal in this country you know." The Ward Manager replied, "Goodness, no, of course not." I was upset and said, "Just let her be pain free". [paragraph] The syringe driver was applied and my mother was catheterised to ease the nursing of her. She had not had anything by mouth since midday Monday 17th August 1998. [paragraph] A little later Dr BARTON [sic] appeared and confirmed that a haemetoma [sic] was present and that this was the kindest way to treat my mother. She also stated, "And the next thing will be a chest infection." [In her witness statement Mrs Mackenzie has stated that 'DR BARTON [sic] then said, "Well, of course, the next thing for you to expect is a chest infection".' [[paragraph] I would like to clarify the issue of my 'agreement' to the syringe driver process. It was not a question, in my mind, of 'agreement'. [paragraph] I wanted my mother's pain to be relieved. I did not 'agree' to my mother being simply subjected to a course of pain relief treatment, at the Gosport War Memorial Hospital, which I knew would effectively prevent steps being taken to facilitate her recovery and would result in her death. [paragraph] I also wanted my mother to be transferred back to the Haslar Hospital where she had, on two occasions, undergone operations and recovered well. My mother was not, I knew, terminally ill and, with hindsight, perhaps I should have challenged Dr BARTON [sic] more strongly on this issue. [paragraph] In my severe distress I did not but I do believe that my failure to pursue the point more vigorously should not have prevented Dr BARTON [sic] from initiating an alternative course of action to that which was taken, namely a referral back to the Haslar Hospital where my mother's condition could have been treated and where an offer had already been made to do so. [paragraph] I accept that my mother was unwell and that her physical, reserves had been depleted. However, she had, during the preceding days and weeks, demonstrated great courage and strength. I believe that she should have been given a further chance of recovery especially in the light of the fact that her condition had, it would seem likely. been aggravated by poor quality service and avoidable delay experienced whilst in the hands of those whose responsibly [responsibility] it was to care for her. [paragraph] My mother's bodily strength allowed her to survive a further 4 days using her reserves. She suffered kidney failure on 19th August and no further urine was passed. The same catheter remained in place until

her death. [paragraph] Because the syringe driver was deemed to be essential following the night of several doses of pain relief my mother's condition gradually deteriorated during the next few days, as I knew it inevitably would, and she died on Friday the 21st August 1998.'

- 15.14. It is noted that Mrs LACK had made contemporaneous hand-written notes comprising five numbered pages. In her Witness Statement she records these '... are in the form of a basic chronology and I incorporated within them a series of questions which focused on particular areas of concern in respect of which I sought an explanation or clarification from the hospital authorities. Following presentation of my notes we were visited on the ward by Mrs Sue HUTCHINGS [sic] on 20.8.98.'
 - 15.14.1. Mrs LACK also made a further one page of contemporaneous hand-written notes. In these she states she was so appalled about her mother's condition, discomfort and severe pain that she visited Haslar Hospital at about lunchtime on 17th August 1998 to ask questions about her mother's condition before she [Mrs RICHARDS] had left the Haslar Hospital ward for her second transfer to Gosport War Memorial Hospital. She learned that, prior to her discharge from Haslar Hospital on 17th August 1998, her mother had been eating, drinking, using a commode and able to stand if aided. Mrs LACK also states in this contemporaneous record that 'On leaving the ward [at Haslar Hospital at about lunchtime on 17th August 1998] I bumped into the Dr [doctor] who had been in casualty theatre for my mothers [sic] second [sic] operation. He was with consultant when all the procedures were explained to me on Friday 14th [August 1998] He said "How's your mother". I explained the current position to him in detail. I told him that she was in severe pain since the transfer which had been undertaken a short time earlier. He said "We've had no referral. Get them to refer her back. We'll see her."
- 15.15. It is noted that a Discharge Letter from the Royal Hospital Haslar describes Mrs RICHARDS' condition on discharge on 17th August 1998 as "She can, however, mobilise fully weight bearing."
- 15.16. It is also noted that Mrs LACK has stated that she and her sister were constantly at the Gosport War Memorial Hospital, day and night, from 17th August 1998 until the time their mother died.
 - 15.16.1. Mrs MACKENZIE has stated that 'I stayed with my mother until very late that Tuesday night [18th August 1998]. it was past midnight, in fact, when my son arrived from London. As from the Wednesday night my sister also sat with me all night long and we both remained, continuously, until twenty past nine on the following Friday evening [21st August 1998] when my mother died. During that time Dr Barton [sic] did not visit my mother. I am quite certain about this because our mother was not left alone, in her room, at

- any time apart from when she was washed by the nursing staff. Either my sister or I, [sic] was with her throughout.'
- 15.16.2. Mrs MACKENZIE has also stated that although she did not sign the contemporaneous notes made by Mrs LACK she '... was a party, at times, to the preparation process and where, on occasions, my sister has referred to 'I' in fact it could read 'we' as we were together when certain events occurred.'
- 15.16.3. Mrs MACKENZIE continues 'It seems to me that she [Mrs RICHARDS] must have had considerable reserves of strength to enable her to survive from Monday until Friday, five days, when all she had was a diet of Diamorphine and no hydration whatsoever, apart from porridge, scrambled eggs and a drink, at the Royal Hospital Haslar, before transfer to the Gosport War Memorial Hospital.'

Appendix C

Glossary

- Acetabulum is the name given to the two deep socket into which the head of the thigh bone (femur) fits at the hip joint.
- ADL [activities of daily living] are those physical activities of daily life necessary for normal human functioning and include getting up, washing, dressing, preparing a simple meal, etc.
- Analgesia is the relief of pain. This can be achieved by physical means including warmth and comfortable positioning as well as by the use of drugs. The aim is to keep patients pain free with minimal side effects from medication.
- Bronchopneumonia is inflammation of the lung usually caused by bacterial infection. Appropriate antibiotic therapy, based on the clinical situation and on microbiological studies, will result in complete recovery in the majority of patients. It can contribute to the cause of death in moribund patients.
- Co-codamol is a drug mixture consisting of paracetamol and codeine phosphate, which is used for the relief of mild to moderate pain.
- Cyclizine is a drug used to prevent nausea and vomiting, vertigo, and motion sickness.
- **Dementia** is the name given to a condition associated with the acquired loss of intellect, memory, and social functioning.
- Diamorphine, also known as heroin, is a powerful opioid analgesic.

Haematoma is an accumulation of blood within the tissues, which clots to form a solid swelling.

Haloperidol, a drug used in the treatment of psychoses including schizophrenia and mania and also for the short-term management of agitation, excitement, and violent or dangerously impulsive behaviour. Dosage for all indications should be individually determined and it is best initiated and titrated under close clinical supervision. For patients who are elderly the normal starting dose should be halved, followed by a gradual titration to achieve optimal response. It is not licensed for subcutaneous administration (see licensed below).

Hemiarthroplasty is the surgical remodelling of a part of the hip joint whereby the bone end of the femur is replaced by a metal or plastic device to create a functioning joint.

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

Lactulose is a preparation taken by mouth to relieve constipation.

A microgram is one millionth of a gram and is not to be confused with a milligram dosage of a drug, which is one thousand times larger.

Midazolam is a sedative drug about which there have been reports of respiratory depression. It has to be use with caution in elderly people. It is used for intravenous sedative cover for minor surgical procedures. It is also used for sedation by intravenous injection in critically ill patients in intensive care. It can be given intramuscularly. In the management of overdosage special attention should be paid to the respiratory and cardiovascular functions in intensive care. It is not licensed for subcutaneous administration (see licensed above).

Morphine is an opioid analgesic used to relieve severe pain.

Oramorph is a drug used in the treatment of chronic pain. It contains morphine and is in the form of a liquid. 10mls of Oramorph at a strength of 10mgs of morphine sulphate in 5mls of liquid is an appropriate first dose to give to a person in severe pain, which had not responded to other less potent, pain relieving drugs.

Respiratory depression is the impairment of breathing by drugs or mechanical means which leads to asphyxia and, if uncorrected, to death.

Subcutaneous means beneath the skin.

A syringe driver is a power driven device for pushing the plunger of a syringe forward at an accurately controlled rate. It is an aid to administering medicinal preparations in liquid form over much longer periods than could be achieved by injecting by hand. In this case the syringe driver used was a Sims Graseby MS 26 Daily rate syringe driver which operates over periods of 24-hours.

Tradazone is a drug used in the treatment of depressive illness, particularly when sedation is required.

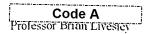
Unlicensed medicines. In order to ensure that medicines are safe, effective and of suitable quality, they must have a product licence (now called a market authorisation) before being marketed in the United Kingdom. Unlicensed drugs are not licensed for use for any indication or age group. Licensing arrangements constrain pharmaceutical companies but not prescribers. The Medicines Act 1968 and European legislation make provision for doctors to use unlicensed medicines. Individual prescribers of unlicensed medicines, however, are always responsible for ensuring that there is adequate information to support the quality, efficacy, safety and intended use of a drug before using it.

A **Zimmer frame** is a lightweight, but sturdy, frame the patient can use for support to assist safe walking.

APPENDIX D

Texts used for reference have included:

- 1. Adam J. ABC of palliative care: The last 48 hours. *British Medical Journal* 1997; 315; 1600-1603.
 - 1.1. This paper is from the widely read, British Medical Journal which is published weekly and received by about 30,000 general practitioners and 45,000 hospital doctors in England and Wales. It records that treatment with opioids (viz. morphine and diamorphine) should be individually tailored, the effect reviewed, and the dose titrated accordingly.
- 2. ABPI Compendium of data sheets and summaries of product characteristics 1998-99: with the code of practice for the Pharmaceutical Industry. Datapharm Publications Limited, 12 Whitehall, London SW1A 2DY.
- 3. Breggin P R. *Toxic psychiatry*. *Drugs and electroconvulsive therapy: the truth and the better alternatives.* 1993. HarperCollins Publishers. London. pp. 578.
- 4. British Medical Association and the Royal Pharmaceutical Society of Great Britain. British National Formulary. Number 32 (September 1996). The Pharmaceutical Press. Oxford.



- Cecil Textbook of Medicine. eds. J.C. Bennett & F. Plum. W.B. Saunders Co. 20th Edition 1996.
- 6. Letter from Clive Ward-Able (Medical and Healthcare Director) and Lee Neubauer BSc (Hons) (New Product Specialist), Roche Pharmaceuticals.
 - 6.1. A copy of this letter has already been supplied to the Police and reports that the product licence does not cover the administration of Hypnovel® (midazolam) by subcutaneous injection.
- 7. Roche Pharmaceuticals. Hypnovel® [midazolam]. Summary of product characteristics.
- 8. Letter from Dr R J Donnelly, Medical Director of Janssen-Cilag Ltd.
 - 8.1. A copy of this letter has already been supplied to the Police and reports that HaldolTM decanoate (haloperidol) is not licensed for subcutaneous use.
- 9. Letter from Miss Jo Medlock, Manager of Medical Information and Pharmacovigilance, Norton Pharmaceuticals.
 - 9.1. A copy of this letter has already been supplied to the Police and reports that SerenaceTM (haloperidol) ampoules are not licensed for subcutaneous administration.
- 10. MeReC. Pain control in palliative care. MeReC Bulletin National Prescribing Centre, 1996; 7 (7); 25-28.
 - 10.1. MeReC is the abbreviation for the 'Medicines Resource Centre'. This bulletin is sent free to all general practitioners in England and Wales and also to NHS Hospital and Community Pharmacists. The list of those who receive this bulletin is updated every few weeks.
- 11. Sims Graseby Limited. MS 16A Syringe Driver. MS 26 Syringe Driver: Instruction manual. Sims Graseby Limited. 1998.

Appendix E

The writer's qualifications and experience including the management of dying patients

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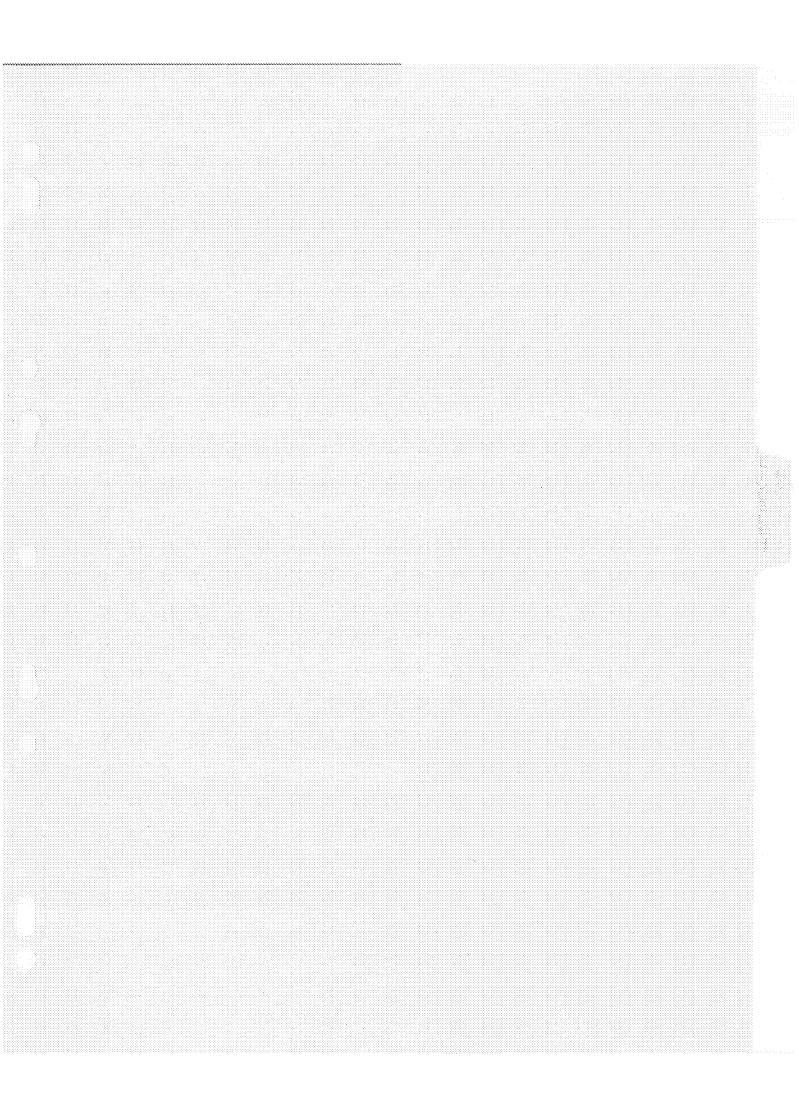
Code A

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Code A

signed ... Code A

date 10 July 2001



Concerning the case of Gladys Mable Richards deceased

Prepared for:

Hampshire Constabulary Major Crime Complex, Fratton Police Station, Kingston Crescent, North End, Portsmouth, Hampshire PO2 8BU

by: Professor Brian Livesley MD FRCP
The University of London's Professor in the Care of the Elderly
Imperial College School of Science, Technology, & Medicine
The Chelsea and Westminster Hospital, London SW10 9NH

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.

Summary

- 1. At the age of 91 years, Mrs Gladys RICHARDS was an in-patient in Daedalus ward at Gosport War Memorial Hospital.
- 1.1. Dr Jane Ann 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.
- 1.2. Mr Philip James BEED, Ms Margaret COUCHMAN, and Ms Christine JOICE were also knowingly responsible for the administration of these drugs.
- 1.3. As a result of being given these drugs, Mrs RICHARDS was unlawfully killed.

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Introduction

- 2. The documents with which I have been provided and the visits I have made to the hospitals involved in this enquiry are listed in the Appendix A.
- 2.1. Appendix B contains facts of the environment provided by the statements of Mrs Gillian MACKENZIE (the elder daughter of Mrs Gladys RICHARDS (deceased)) and Mrs Lesley Frances LACK (the younger daughter).
- 2.2. I have indicated any medical terms in **bold type**. I have defined these terms in a glossary in Appendix C.
- 2.3. I have included in Appendix D references to published material.
- 2.4. Appendix E contains details of my qualifications and experience.
- 2.5. This report has been presented on the basis of the information available to me—should additional information become available my opinions and conclusions may be subject to review and modification.

Information relating to Mrs Gladys Richards (deceased)

- 3. Mrs Gladys Mable RICHARDS (née Beech) was born on 13th April 1907 and died on 21st August 1998 aged 91 years.
- 3.1. Mrs Richards has two daughters. They are Mrs Gillian MACKENZIE (the elder daughter) and Mrs Lesley Frances LACK.
 - 3.1.1. Mrs Lack is a retired Registered General Nurse. She retired during 1996 after 41 years continuously in the nursing profession. For 25 years prior to her retirement she was involved in the care of elderly people. For 20 years prior to retirement she held supervisory and managerial positions in this particular field of nursing.
- 3.2. The Glen Heathers Nursing Home is a private registered nursing and residential home at Lee on the Solent, Hampshire. Dr J BASSETT is a general practitioner who visits.
- 3.3. The Royal Hospital Haslar is an acute general hospital in Gosport, Hampshire serviced by the Armed Forces at the time of the incident but available as a National Health Service facility to local people.
- 3.4. Gosport War Memorial Hospital is part of the Portsmouth Healthcare NHS Trust.

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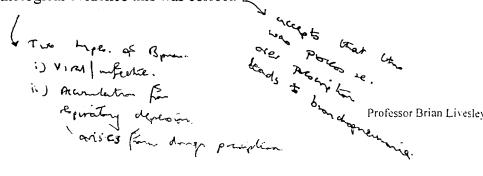
- 3.4.1. Daedalus ward is a continuing care and rehabilitation ward at Gosport War Memorial Hospital.
- 3.5. Dr Jane Ann BARTON is a registered medical practitioner who in 1988 took up a part-time post as clinical assistant in elderly medicine. This post became centered at Gosport War Memorial Hospital. She retired from this part-time post in the year 2000.
- 3.6. Mr Philip James BEED is the clinical manager and charge nurse on Daedalus ward at Gosport War Memorial Hospital. Ms Margaret COUCHMAN and Ms Christine JOICE are registered general nurses who were working on Daedalus ward at the time of the incident.
- 3.7. Dr Anthea Everista Geredith LORD is a consultant physician, within the department of elderly medicine of Portsmouth Healthcare NHS Trust, who was usually responsible for the patients on Daedalus ward and who was on study leave on 17/18 August 1998.
 - 3.7.1. Other consultant physicians from the department of elderly medicine provide on-call consultant physician cover when Dr LORD is absent from duty.

Synopsis

- 4. Mrs Gladys Mable RICHARDS died on 21st August 1998 while receiving treatment on Daedalus ward at Gosport War Memorial Hospital.
- 4.1. Some fours years earlier, on 5th August 1994, Mrs RICHARDS had become resident at the Glen Heathers Nursing Home.
- 4.2. On 29th July 1998, Mrs RICHARDS developed a fracture of the neck of her right femur [thighbone] and she was transferred to the Royal Hospital Haslar, Gosport.
- 4.3. Despite her confused state, Mrs RICHARDS was considered by medical staff at the Royal Hospital Haslar to be suitable for implantation of an artificial hip joint. This took place on 30th July 1998.
- 4.4. On 11th August 1998, and having been seen by a consultant geriatrician, Mrs RICHARDS was transferred for rehabilitation to Daedalus ward at Gosport War Memorial Hospital.
- 4.5. Later on 11th August 1998 Dr BARTON saw Mrs RICHARDS. Dr BARTON recorded that Mrs RICHARDS was not obviously in pain but despite this Dr BARTON prescribed Oramorph [an oral morphine preparation] four hourly orally. Dr BARTON also prescribed for Mrs RICHARDS 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. At the end of a short case note, Dr

BARTON wrote 'I am happy for nursing staff to confirm death'. Although prescribed, these drugs were not administered at that time.

- 4.6. On 13th August 1998, Mrs RICHARDS artificial hip joint became dislocated9.
- 4.7. The following day, 14th August 1998, Dr BARTON arranged for Mrs RICHARDS to be transferred back to Haslar Hospital where the dislocation of the hip was reduced.
- 4.8. Three days later, on 17th August 1998, Mrs RICHARDS was returned to the Gosport War Memorial Hospital on a sheet and not on a stretcher. She was very distressed when she reached Daedalus ward.
- 4.9. There is no evidence that Mrs RICHARDS, although in pain, had any specific life-threatening and terminal illness that was not amenable to treatment and from which she could not be expected to recover.
- 4.10. Despite this, and 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.
 - 4.10.1. Neither midazolam nor haloperidol is licensed for subcutaneous administration.
- 4.11. 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 in any appropriate manner.
- 4.12. There is no evidence that in fulfilling her duty of care Dr BARTON reviewed appropriately Mrs RICHARDS's clinical condition from 18th August 1998 to determine if any reduction in the drug treatment being given was indicated.
- 4.13. There is no evidence that in fulfilling their duty of care Mr Philip BEED, Ms Margaret COUCHMAN and Ms Christine JOICE reviewed appropriately Mrs RICHARDS's clinical condition from 18th August 1998 to determine if any reduction in the drug treatment they were administering was indicated.
- 4.14. There is, however, indisputable evidence that the subcutaneous administration of drugs by syringe driver continued without modification and during every 24 hours from 18th August 1998 until Mrs RICHARDS died on 21st August 1998.
- 4.15. Although Dr Barton recorded that death was due to bronchopneumonia there is no clinical or pathological evidence this was correct.



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not correct

- 4.16. It is beyond reasonable doubt that the death of Mrs RICHARDS was the result of the continuous subcutaneous administration of diamorphine, haloperidol, midazolam, and hyoscine in the dosages given above.
- 4.17. Dr Jane Ann BARTON had a duty of care to Mrs RICHARDS.
- 4.18. Mr Philip BEED, Ms Margaret COUCHMAN, and Ms Christine JOICE had a duty of care to Mrs RICHARDS.
- 4.19. There was a breach of the duty of care.
- 4.20. Foreseeable injury occurred as a consequence of the breach and resulted in the death of Mrs RICHARDS.
- 4.21. It is my opinion that Mrs Gladys RICHARDS was unlawfully killed.

Relevant aspects of Mrs RICHARDS's medical history

- 5. Mrs RICHARDS became resident at the Glen Heathers Nursing Home on 5th August 1994 at the age of 87 years and although disorientated and confused she was able to wash and dress herself and able to go up and down stairs and walk well.
- 5.1. At the beginning of 1998, she had become increasingly forgetful and less able physically but was inclined to wander and she had about a six months' history of falls.
- 5.2. She also had a past medical history of bilateral deafness for which she required hearing aids (unfortunately these were lost by December 1997 while she was at the Glen Heathers Nursing Home and had not been replaced by July 1998). She had had operations for the removal of cataracts and required glasses (unfortunately these were also lost at the Glen Heathers Nursing Home).
 - 5.2.1. On 8th July 1998 her general practitioner, Dr J BASSETT wrote to the audiologist at Queen Alexandra Hospital, Cosham requesting an 'URGENT [sic]' domiciliary visit to Glen Heathers Nursing Home. This was '... with a view to supplying her [Mrs RICHARDS] with two new hearing aids.... Since her poor hearing probably contributes to her confusional state I would be grateful if you would visit with a view to fitting of replacement aids as soon as possible please.'
- 5.3. On 29th July 1998, Mrs RICHARDS developed a fracture of the neck of her right femur [thighbone] and she was transferred to the Royal Hospital Haslar, Gosport.
 - 5.3.1. In the Accident & Emergency department she was given 2.5mg of morphine and 50 mg of cyclizine at 2300 hours to relieve her pain and distress. She

was known to be taking haloperidol 1mg twice daily and Tradazone 100mg at night.

- 5.4. On 30th July 1998 Mrs RICHARDS had a right cemented hemiarthroplasty [an artificial hip joint inserted].
 - 5.4.1. Post-operatively she was given 2.5 mg morphine intravenously on July 30th at 0230 hours, 31st at 0150 and 1905 hours, and on August 1st at 1920 hours and 2nd at 0720 hours. From August 1st –7th she was weaned over to two tablets of co-codamol, requiring these on average twice daily for pain relief.
 - 5.4.2. On 3rd August 1998 it was noted 'All well. Sitting out early mobilization'.
- 5.5. On 5th August 1998, Dr REID, a consultant geriatrician, saw her. He stated in a letter that '... she appeared to have a little discomfort on passive movement of the right hip. I understand that she has been sitting out in a chair and I think that, despite her dementia, she should be given the opportunity to try to re-mobilise. I will arrange for her transfer to Gosport Memorial Hospital.'
 - 5.5.1. Dr REID also noted that Mrs RICHARDS had continued on Haloperidol and '... her Trazodone has been omitted. According to her daughters it would seem that since her Tradozone has been omitted she has been much brighter mentally and has been speaking to them at times.'
- 5.6. A discharge letter, dated 10th August 1998, was sent by the sergeant staff nurse at the Royal Hospital Haslar and addressed to 'The Sister in Charge Ward [sic] Memorial Hospital, Bury Road, Gosport, Hants.' It contained the following information:-
 - 5.6.1. After the operation Mrs RICHARDS became '...fully weight bearing, walking with the aid of two nurses and a Zimmer frame.' She was noted to require 'total care with washing and dressing, eating and drinking....' She was '... continent, when she become[s] fidgety and agitated it means she wants the toilet....' She 'Occasionally says recognisable words, but not very often.' Her wound 'Is healed, clean and and dry.'
- 5.7. On 11th August 1998, Mrs RICHARDS was transferred to Daedalus ward at the Gosport War Memorial Hospital.
 - 5.7.1. There is an unsigned 'Summary' record which is apparently a Nursing record and this states:-
 - 5.7.1.1. '11-8-98 Addmitted [sic] from E6 Ward Royal Hospital Haslar, into a continuing care bed. Gladys had sustained a right fractured neck of Femur on 30th July 1998 in Glen Heathers Nursing Home. She has had a right cemented hemi-arthroplasty and she is now fully weight bearing, walking with the aid of two nurses and a

Zimmer frame. Daughter visits regularly and feeds mother. She wishes to be informed Day or night of any deterioration in mothers condition....'

- 5.7.2. The contiguous 'Assessment Sheet' states, 'Patient has no apparent understanding of her circumstances due to her impaired mental condition ... Deaf in both ears ... Cataract operation to both eyes ... occasionally says recognisable words, but not very often ... soft diet. Enjoys a cup of tea ... requires feeding ... Dental/Oral status Full "Set" keeps teeth in at night.'
- 5.7.3. The 'Patient Medication Information' states, '11.8.98 ... Haloperidol O[rally] 1 mcg [looks like 'mcg' but probably is 'mg' since this drug is not prescribed in single microgram doses] B.D. [twice daily]'
- 5.8. ??[initials]B [subsequently identified as Dr BARTON] has written in the medical case records '11-8-98 Transferred to Daedalus Ward Continuing Care.... O/E [on examination] Impression frail demented lady [paragraph] not obviously in pain [paragraph] Please make comfortable [paragraph] transfers with hoist Usually continent needs help with ADL [activities of daily living].... I am happy for nursing staff to confirm death.'
- 5.9. At 1300 hours on the 13th August 1998 the Nursing Contact Record states 'Found on floor at 13.30hrs [sic]. Checked for injury none apparent at time hoisted into safer chair 20.00 [hours][altered on record to 19.30] pain Rt [right] hip internally rotated. Dr BRIGG contacted advised Xray AM [in the morning] & analgesia during the night. Inappropriate to transfer for Xray this PM [evening] [initialled signature (? by whom)] RGN [Registered General Nurse] [next line] Daughter informed.'
- 5.10. Dr BARTON has recorded '14-8-98 Sedation/pain relief has been a problem screaming not controlled by haloperidol 1 [illegible symbol or word] but very sensitive to oramorph. Fell out of chair last night ... Is this lady well enough for another surgical procedure?'
- 5.11. In her contiguous note Dr BARTON has recorded '14-8-98 Dear [?] Cdr [Commander] SPALDING Further to our telephone conversation thank you for taking this unfortunate lady who slipped from her chair at 1.30 pm yesterday and appears to have dislocated her R[ight] hip.... She has had 2.5ml of 10mg/5ml Oramorph at midday.'
 - 5.11.1. According to the letter signed by Philip BEED, Mrs RICHARDS was given 10mgs of Oramorph at 1150 hours on 14th August 1998 prior to being transferred back to the Royal Hospital Haslar.
- 5.12. The Nursing Contact Record at Daedalus ward continues:-

- 5.12.1. '14/8/98 am [morning] R[ight] Hip Xrayed Dislocated [paragraph]
 Daughter seen by Dr BARTON & informed of situation. For transfer to
 Haslar A&E [accident and emergency department] for reduction under
 sedation [initialled signature]'
- 5.12.2. 'pm [afternoon or evening of 14th August 1998] Notified that dislocation has been reduced. [Mrs RICHARDS] To stay in Haslar [hospital] for 48 hours then return to us [[initialled signature] Family aware.'
- 5.13. At the Royal Hospital Haslar (at 1400 hours) Xray having confirmed that the hemiarthroplasty had dislocated, intravenous sedation using 2 mgs of midazolam allowed the dislocation to be corrected by traction. The procedure was described as 'Under sedation c [with] CVS/RS [cardiovascular and respiratory systems] monitoring. ... Easy reduction.' Mrs RICHARDS was noted to be 'rather unresponsive following the sedation. The [She] gradually became more responsive....' She was then admitted the Royal Hospital for 48 hours observation.
- 5.14. Apart from two tablets of co-codamol on the 15th August 1998, she did not need to be given any pain relief following the reduction of her hip dislocation.
 - 5.14.1. Two days later, on 17th August 1998, it was recorded that 'She was fit for discharge that day and she was to remain in straight knee splint for four weeks. In the discharge letter from Haslar Hospital it was also recorded that Mrs RICHARDS was to return to Daedalus Ward. It was further stated that 'She has been given a canvas immobilising splint to discourage any further dislocation, and this must stay in situ for four weeks. When in bed it is advisable to encourage abduction by using pillows or abduction wedge. She can however mobilise fully weight bearing.'
- 5.15. On 17th August 1998 it was also recorded that she was 'Fit for discharge today (Gos[port] War Mem[orial hospital). To remain in straight knee splint for 4/52 [four weeks] ... No follow-up unless complications.'
- 5.16. She was returned to Daedalus ward in the Gosport War Memorial Hospital later that day but in a very distressed state. Their nursing record states 'Returned from R.N. Haslar, patient very distressed appears to be in pain. No canvas under patient transferred on sheet by crew To remain in straight knee splint for 4/52 [four weeks] For pillow between legs at night (abduction) No follow-up unless complications.'
 - 5.16.1. Mrs RICHARDS was given Oramorph 2.5 mg in 5mls. The nursing record for 17th August 1998 further states '1305 [hours] ... Daughter reports surgeon to say her mother must not be left in pain if dislocation occurs again. Dr Barton contacted and has ordered an Xray. M. COUCHMAN. [paragraph] pm Hip Xrayed at 1545 [hours] Films seen by Dr PETERS & radiologist &

no dislocation seen. For pain control overnight & review by Dr BARTON mane [in the morning]. ?[illegible nurse signature]

- 5.16.1.1. This radiograph was reported by Dr. DOMJAN, Consultant Radiologist as showing 'RIGHT HIP: The right hemiarthroplasty is relocated in the **acetabulum**.'
- 5.17. On 17th August 1998, Dr BARTON noted 'Readmission to Daedalus from RHH [Royal Hospital Haslar] Closed reduction under iv [intravenous] sedation remained unresponsive for some hours now appears peaceful. Plan Continue haloperidol [paragraph] Only give oramorph if in severe pain See daughter again.'
- 5.18. On 18th August 1998, Dr BARTON recorded 'Still in great pain [paragraph] Nursing a problem. [paragraph] I suggest sc[subcutaneous] diamorphine/Haloperidol/midazolam [paragraph] I will see daughters today [paragraph] please make comfortable.'
- 5.19. The nursing Contact Record on Daedalus ward in the Gosport War Memorial Hospital continues:-
 - 5.19.1. '18/8/98 am Reviewed by Dr Barton. For pain control via syringe driver. [paragraph] 1115 Treatment discussed with both daughters [Mrs LACK and Mrs MACKENZIE]. They agree to use of syringe driver to control pain [Mrs LACK disagrees with this statement] & allow nursing care to be given. [paragraph] 1145 Syringe driver diamorphine 40 mg. Haloperidol 5 mg, Medazolam [midazolam] 20 mg commenced'
 - 5.19.2. '18/8/98 20.00 Patient remained peaceful and sleeping. Reacted to pain when being moved this was pain in both legs. [paragraph] Daughter quite upset and angry about mother's condition, but appears happy that she is pain free at present. C JOICE.'
 - 5.19.3. The nursing Contact Record continues 'Daughter, Jill, stayed the night with Gladys [Mrs RICHARDS], grandson arrived in early hours of morning [initialled signature; dated '19/8/98'] [paragraph] He would like to discuss Grand mother's condition with someone either Dr. Barton or Phillip Beed later today [initialled signature]' [paragraph] '19/8/98 am Mrs Richards comfortable. [paragraph] Daughters seen. Unhappy with various aspects of care, complain[t] to be handled officially by Mrs S Hutchings Nursing coordinator [initialled signature]'
 - 5.19.4. It is noted that there is no continuing nursing Contact Record for the 20th August 1998.

- 5.19.5. The contiguous nursing Contact Record states '21/8/98 12.13 [hours]
 Patient's [Mrs RICHARDS] overall condition deteriorating, medication keeping her comfortable. Daughters visited during the morning. C JOICE'
- 5.20. Dr BARTON's next contiguous medical record was on 21st August 1998 when she wrote 'Much more peaceful [paragraph] needs Hyoscine for rattly chest'. Nurse GRIFFIN made the next note in the medical records on 21st August 1998 stating that Mrs Richards was dead at 2120 hours.
- 5.21. The Nursing Care Plan records state:-
 - 5.21.1. '12.8.98 Requires assistance to settle and sleep at night.... 12.8.98

 Haloperidol given at 2330 [hours] as woke from sleep very agitated shaking and crying. Didn't settle for more than a few minutes at a time. Did not seem to be in pain.'
 - 5.21.2. '13.8.98 oromorph at 2100 [hours] Slept well [initialled signature] [paragraph] For Xray tomorrow morning [initialled signature]'
 - 5.21.3. '14.8.98 Same pain in rt[right] leg / ?[query] hip this am. [initialled signature]'
 - 5.21.4. 'Re-admitted 17/8/98'
 - 5.21.5. '17.8.98 Oromorph [Oramorph] 10mg/5ml at present.'
 - 5.21.6. '18.8.98 Now has a syringe driver with 40mgs Diamorphine comfortable. Daughters stayed. [initialled signature]'
 - 5.21.7. 'Daughters stayed with Gladys [Mrs RICHARDS] overnight. [initialled signature]'
 - 5.21.8. There is no record of continuance of the Nursing Care Plan for 20th and 21st August 1998.
 - 5.21.9. After Mrs RICHARDS had been readmitted to Daedalus ward on 17th August 1998, there is no record between 17th and 21st August 1998 in the patient Nursing Care Plan for 'Nutrition'. On 21st August the record states 'no food taken [initialled signature]'.
 - 5.21.9.1. There is no record that Mrs RICHARDS was offered any fluids.
 - 5.21.10. Similarly, the Nursing Care Plan for 'Constipation' shows no record between 17th and 21st August1998. On 21st August the record states 'BNO [bowels not open] [initialled signature]'

- 5.21.11. The Nursing Care Plan for 'Personal Hygiene' states:-
 - 5.21.11.1. '18.8.98 Complete Bed Bath given plus oral [Signature] Hygiene [second signature]'
 - 5.21.11.2. '18.8.98 Night: oral care given frequently'
 - 5.21.11.3. '19.8.98 Nightie changed & washed, repositioned. Apparently pain free during care [initialled signature]'
 - 5.21.11.4. It is noted that there is no record of Mrs Richards being attended to for 'Personal Hygiene' on 20th August 1998.
 - 5.21.11.5. '21.9.98 General care and oral hygiene given [initialled signature]'
- 5.22. The drugs prescribed for Mrs RICHARDS at Gosport War Memorial Hospital from the time of her admission there on 11th August 1998 are described below.

Drugs prescribed for Mrs RICHARDS at Gosport War Memorial Hospital

- 6. Dr BARTON wrote the following drug prescriptions for Mrs RICHARDS.
- 6.1. On 11th August 1998:-
 - 6.1.1. Oramorph 10mgs in 5mls to be given orally four hourly. On the Administration Record these doses are recorded as being given
 - 6.1.1.1. twice on 11th August 1998 (10mg at 1015 [?1215] and 10mg at 1145 [?pm]),
 - 6.1.1.2. once on 12th August (10mg at 0615),
 - 6.1.1.3. once on 13th August (10mg at 2050),
 - 6.1.1.4. once on 14th August (5ml [10mg] at 1150),
 - 6.1.1.5. four times on 17th August (2.5ml [5mg] at 1300, 2.5ml [5mg] at ?????[time illegible], 2.5ml [5mg] at1645, and 5ml [10mg] at 2030),
 - 6.1.1.6. and twice on 18th August 1998 5ml [10mg] at 01230[sic and? meaning 0030 hours] and 5ml [10mg] at [?]0415).

- 6.1.2. Diamorphine at a dose range of 20 200 mg to be given subcutaneously in 24 hours.
 - 6.1.2.1. None of this diamorphine prescription is recorded on the Administration Record as having been given between 11th 14th August inclusive.
- 6.1.3. Hyoscine at a dose range of 200 800 mcg [micrograms] to be given subcutaneously in 24 hours.
 - 6.1.3.1. None of this hyoscine prescription is recorded on the Administration Record as having been given between 11th 14th August inclusive.
 - 6.1.3.2. This prescription was administered at a dose level of 400mcg [micrograms] on 19th, 20th, and 21st August 1998 commencing at 1120, 1045, and 1155 hours respectively.
- 6.1.4. Midazolam at a dose range of 20-80 mgs to be given subcutaneously in 24 hours.
 - 6.1.4.1. None of this midazolam prescription is recorded on the Administration Record as having been given between 11th 14th August inclusive.
 - 6.1.4.2. This prescription was administered at a dose level of 20mg on 19th, 20th, and 21st August 1998 commencing at 1120, 1045, and 1155 hours respectively.
- 6.1.5. Haloperidol Img orally twice daily. It is noted that at the top of this prescription chart 'TAKES MEDICINE OFF A SPOON' [sic] is clearly written.
 - 6.1.5.1. She was give 1mg of haloperidol at 1800 hours on 11th August 1998, at 0800 and 2330 hours on 12th August 1998, at 0800 and 1800 hours on 13th August 1998.
 - 6.1.5.2. In addition, on 13th August 1998, Mrs RICHARDS was prescribed haloperidol 2mgs in 1ml to be administered orally as required at a dose of 2.5ml [this figure has been altered and also can be read as 0.5 ml] to be given 'IF NOISY' [sic]. She was given a dose [quantity not stated bearing in mind the altered prescription] at 1300 on 13th August 1998.
 - 6.1.5.3. She was also given 1mg of haloperidol at 0800 hours on 14th and also at 1800 hours on 17 August 1998.

- 6.1.6. It is noted that, apart from 2330 hours on 12 August 1998, at the above times when Mrs RICHARDS was given haloperidol she was also give 10ml of Lactulose [a purgative].
- 6.2. On 12th August 1998:-
 - 6.2.1. Oramorph 10mgs in 5mls to be given orally in a dose of 2.5 mls four hourly [equivalent to 5mgs of oramorph].
 - 6.2.1.1. Although this drug was apparently not administered its prescription was written up on the 'Regular Prescription' chart but at the side in an ink-drawn box there are the letters PRN [meaning that the prescription is to be administered as required].
 - 6.2.2. Oramorph 10mgs in 5mls to be given orally once at night.
 - 6.2.2.1. Although this drug was apparently not administered its prescription was also written up on the 'Regular Prescription' chart but at the side in an ink-drawn box there are the letters PRN [meaning that the prescription is to be administered as required].
- 6.3. 18th August 1998:-
 - 6.3.1. Diamorphine at a dose range of 40-200mg to be administered subcutaneously in 24 hours
 - 6.3.2. Haloperidol a dose range of 5-10 mgs to be administered subcutaneously in 24 hours.
- 6.4. On 18th, 19th, 20th, and 21st August 1998, Mrs RICHARDS was given simultaneously and subcutaneously midazolam 20mgs [this had been prescribed on 11th August 1998 but was first administered on 18th August 1998], diamorphine 40mgs, and haloperidol 5mgs in 24 hours.
 - 6.4.1. These drugs are recorded as being administered at the same time of day on each of the four days they were given. They were administered at 1145, 1120, 1045, and 1155 for 18th, 19th, 20th, and 21st August 1998 respectively. All these drugs were administered at the times stated and were signed off by initials as being co-administered by the same person each day. Over the four days of 18th, 19th, 20th, and 21st August 1998, at least three nurses were involved in administering these drugs.
 - 6.4.2. It is noted that on the 19th, 20th, and 21st August 1998 the drugs midazolam 20mgs, diamorphine 40mgs, and haloperidol 5mgs were also co-administered

- subcutaneously in 24 hours with 400mcg of hyoscine [this last drug had been prescribed by Dr BARTON to be given as required on 11th August 1998 but its administration was not commenced until 19th August 1998].
- 6.4.3. It is also noted that the drugs for subcutaneous administration were all not prescribed at specific starting dosages but each was prescribed for a wide range of dosages and for continuous administration over 24-hour periods.
- 6.4.4. According to the prescription charts these drugs were signed for as being administered to Mrs RICHARDS via the syringe driver by Mr Philip BEED on 18th and 19th August 1998, by Ms Margaret COUCHMAN on 20th August 1998, and by Ms Christine JOICE on 21st August 1998.

Death certification and cremation

- 7. The circumstances of Mrs RICHARDS death have been recorded as follows:
- 7.1. In a document [Case no. 1630/98] initialled by the Coroner on 24th August 1998 'Reported by Dr BARTON [sic]. Deceased had undergone surgery for a fractured neck of femur. Repaired. Death cert[ificate] issued. [paragraph] THOMAS [sic]
- 7.2. The cause of death was accepted by the Coroner on 24th August 1998 as being due to:-
 - 7.2.1. '1(a) Bronchopneumonia'.
 - 7.2.2. The death was certified as such by Dr J A BARTON and registered on 24th August 1998.
- 7.3. The body was cremated.

My opinion

- 8. At the age of 91 years, and despite her confused mental state, Mrs RICHARDS had been considered well enough for two operations on her right hip.
- 8.1. After her second operation she was transferred back to Daedalus ward at Gosport War Memorial Hospital on 17th August 1998. Following the transfer she was in severe pain.
- 8.2. There is no evidence to show that Mrs RICHARDS, although in pain, had any specific life-threatening and terminal illness that was not amenable to treatment and from which she could not be expected to recover.

- 8.3. It is my opinion, and there is evidence to show, that Mrs RICHARDS was capable of receiving oral medication for the relief of the pain she was experiencing on 17th August 1998.
- 8.4. Mrs RICHARDS was known by Dr BARTON to be very sensitive to Oramorph, an oral morphine preparation, and to have had a prolonged sedated response to intravenous midazolam.
- 8.5. Despite this and without consultation with any other medical person, Dr BARTON prescribed the continuous subcutaneous administration of diamorphine, haloperidol, midazolam, and hyoscine.
- 8.6. The administration of these drugs continued on a 24-hours regime without modifying their dosages according to Mrs RICHARDS's response to them and until Mrs RICHARDS died.
- 8.7. Dr BARTON had a duty of care towards Mrs RICHARDS and was in breach of that duty of care.
- 8.8. Mr Philip BEED, Ms Margaret COUCHMAN, and Ms Christine JOICE each had a duty of care towards Mrs RICHARDS and were in breach of that duty of care.
- 8.9. No other event occurred to break the chain of causation and Mrs RICHARDS's 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.
- 8.10. The terminal sedation Mrs RICHARDS received profoundly compromised her dignity and distorted the memory she left behind for her attentive daughters.
- 8.11. 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.
- 8.12. 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.
- 8.13. There is no clinical or pathological evidence that Mrs RICHARDS' death was caused by pneumonia.
- 8.14. It is beyond reasonable doubt that the cause of Mrs RICHARDS' death was a result of the drugs she was administered continuously by syringe driver from 18th August 1998 until her death on 21st August 1998.

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My conclusions

- 9. My conclusions are as follows:-
- 9.1. Mrs RICHARDS was unlawfully killed by the continuous administration of drugs actively prescribed by Dr BARTON.
- 9.2. Mr Philip BEED, Ms Margaret COUCHMAN, and Ms Christine JOICE knowingly and continuously administered diamorphine, haloperidol, midazolam, and hyoscine to Mrs RICHARDS when they should have recognised the fatal consequences of so doing.

APPENDIX A

- 14. I have received and read the following documents:-
- 14.1. The letter of DCI BURT dated 22nd November 1999 that gave an initial overview of the case.
- 14.2. The documents in the file DCI BURT presented at our meeting on 28th January 2000 as follows:-
 - 14.2.1. 1) Draft (unsigned) statement (MG11) of Lesley HUMPHREY.
 - 14.2.2. 2) Copy of PEC (NHS) T Health Record (LH/1/C).
 - 14.2.3. 3) Copy of RHH Medical Record (AF/1/C).
 - 14.2.4. 4) Draft (unsigned) statement (MG11) of Gillian MACKENZIE.
 - 14.2.5. 5) Draft (unsigned) statement of Lesley LACK.
- 14.3. The documents in the file DCI BURT presented at our meeting on 8th March 2000 including those pursuant to my request of 28th January 2000 (documents WX1, WX2, and YZ were forward to me on 9 March 2000) as follows:-
 - 14.3.1. A Typed copy of Notes prepared by Mrs LACK and given to Portsmouth Healthcare NHS Trust
 - 14.3.2. B Typed copy of additional page of notes which was prepared by Mrs LACK but, apparently, not passed to Portsmouth Healthcare NHS Trust
 - 14.3.3. C Typed copy of Notes prepared by Mrs LACK and given to Social Services
 - 14.3.4. D Typed copy of comments made by Mrs LACK in respect of letter from Portsmouth Healthcare NHS Trust which represented a response to her Notes of complaint (A)
 - 14.3.5. E Typed copy of comments made by Mrs LACK in respect of a Report prepared by Portsmouth Healthcare NHS Trust which resulted in the letter referred to above
 - 14.3.6. F As D above but made by Mrs MACKENZIE
 - 14.3.7. G As E above but made by Mrs MACKENZIE
 - 14.3.8. HI Copy of letter written by Mrs MACKENZIE to DI MORGAN (OIC of initial investigation) plus 5 copies newspaper cuttings
 - 14.3.9. JK Copy of Coroner's Officer's Form
 - 14.3.10. L Copy of letter from Dr REID to S/Cdr SCOTT
 - 14.3.11. M Copy of Report made by Dr LORD during original investigation
 - 14.3.12. N Copy of additional newspaper cutting
 - 14.3.13. O (1) Typed copy of signed statement of Anne FUNNELL (RHH)
 - 14.3.14. O (2) Typed copy of signed statement of Lesley HUMPHREY (Portsmouth Healthcare NHS Trust)
 - 14.3.15. O(3) Copy of signed statement of Lesley LACK

14.3.16.	O (4)	Copy of final draft of Gillian MACKENZIE's statement
14.3.17.	PQ	Copy of schedule of x-ray images (RHH)
14.3.18.	R	Copy of Risk Event Record (Portsmouth Healthcare NHS Trust)
14.3.19.	S(1)	Copy of letter which DCI BURT has sent to Lesley HUMPHREY
	•	(Portsmouth Healthcare NHS Trust) raising various issues
14.3.20.	S (2)	Copy of entries in medical directories 1998/1999 - Dr Jane Ann BARTON
14.3.21.	S (3)	Copy of letter from Mrs MACKENZIE to DCI BURT
14.3.22.	S (4)	Copy of documents which accompanied the two Portsmouth
		Healthcare NHS Trust x-ray images
14.3.23.	T	Copy of various documents which featured in a Social Services Case
		Conference stemming from receipt of Mrs LACK's Notes of complaint (C above)
14.3.24.	UV	Copy of Death Certificate - Mrs RICHARDS
14.3.25.	WX1	Witness Statement of Mrs Gillian MACKENZIE dated March 6 2000
14.3.26.	WX2	Copy of letter from DR J.H. BASSETT to Mrs MACKENZIE with an addendum of five pages being a photocopy from 'Toxic Psychiatry' a book by Dr Peter BREGGEN published by Harper Collins.
14.3.27.	YZ	Two extracts from 'Criminal Law. Diana Rowe. Hodder & Stoughton 1999.'

- 14.4. On 8th March 2000, in the presence of DCI BURT, I visited:-
 - 14.4.1. the Gosport Memorial Hospital and followed the passageways along which Mrs Richards was conveyed and the ward areas in which she was treated; and.
 - 14.4.2. the Royal Hospital Haslar and followed the passageways along which Mrs Richards was conveyed and the ward area in which she was treated.
 - 14.4.2.1. At the Royal Hospital Haslar, on 8th March 2000, in the presence of DCI BURT, I was also shown twelve (12) radiographs relating to Mrs Richards' treatment there on 12th April 1998, 17th July 1998, 14th August 1998, 29th July 1998, and 31st July 1998.
- 14.5. In addition I have read the following the documents given to me by DCI BURT on 12th May 2000 consisting of the following which are numbered below as listed in the two containing ring binders:
 - 14.5.1. E 25 Copy of Glen Care Homes file Re: Gladys RICHARDS supplied by Glen Care Homes
 - 14.5.2. E 22 Copy of Hampshire County Council Social Services file Re: Gladys RICHARDS

- Copy of Glen Care Homes file Re: Gladys RICHARDS supplied 14.5.3. E23 Nursing Homes Inspectorate 14.5.4. E 24 Copy Portsmouth and South East Hampshire Health Authority GP Patient Records of Gladys RICHARDS 14.5.5. Police letter 090300 to Miss CROSS, Haslar Hospital with further D 63 questions 14.5.6. D 65 Letter 100400 from Miss CROSS at Haslar including Patient transfer order and further medical records D 104 Letter 080200 from Mrs. MACKENZIE with notes Re: draft 14.5.7. D 108 Portsmouth NHS Trust Dept. of Diagnostic Imaging report folder 14.5.8. 14.5.9. D 110 Copy typed Gladys RICHARDS Death Certificate dated 240898
- 14.6. I have also read the documents given to me by DCI BURT on 19th July 2000, consisting of copies of the statements made by:-
 - 14.6.1. JOICE Christine
 - 14.6.2. GIFFIN Sylvia Roberta
 - 14.6.3. PULFORD Monica Catherine
 - 14.6.4. WALKER Fiona Lorraine
 - 14.6.5. MARJORAM Catherine
 - 14.6.6. BALDACCHINO Linda Mary
 - 14.6.7. PERKINS Margaret Joan
 - 14.6.8. TUBBRITT Anita
 - 14.6.9. COUCHMAN Margaret
 - 14.6.10. WALLINGTON Kathleen Marv
 - 14.6.11. FLETCHER Anne
 - 14.6.12. COOK Joanne
 - 14.6.13. MOSS JEAN Kathleen
 - 14.6.14. TYLER Christina Ann
- 14.7. I have also read statements, provided on 30th August 2000 by DCI BURT, made by:
 - 14.7.1. Doctor Jane Ann BARTON
 - 14.7.2. Phillip James BEED
- 14.8. I have also received from DCI BURT on 8th September 2000 and read copies of:-
 - 14.8.1. A letter dated 18th August 2000 from Mrs Gillian MACKENZIE to DCI BURT.
 - 14.8.1.1. Enclosed with this letter was a copy of a letter dated 9th August 2000 from Ms Jill BAKER to Mrs Gillian MACKENZIE to which had been added a petition form.

- 14.9. A letter dated 21st August 2000 from Mrs Gillian MACKENZIE to DCI BURT.
 - 14.9.1. Enclosed with this letter was a copy of a letter dated 14th December 1998 from Ms Lesley HUMPHREY, Quality Manager at Portsmouth Healthcare NHS Trust Central Office to Mrs Gillian MACKENZIE. This had enclosed with it a copy of a letter dated 22nd September 1998 from Mr Max MILLETT, Chief Executive of Portsmouth Healthcare NHS Trust.
- 14.10. Copies of Witness Statements (taken by Mrs S HUTCHINGS who led the initial Internal Inquiry as Investigating Officer of Portsmouth Healthcare NHS Trust) as follows:-
 - 14.10.1. On 3rd September 1998 statement consisting of four pages from Mrs Jenny BREWER Staff Nurse Daedalus Ward to which is attached an additional statement (three pages) by Staff Nurse Brewer (the first page of this three pages is headed Portsmouth Healthcare NHS Trust and has been signed on page three by S. N J Brewer RGN and dated 9-9-98 (Reference D142)).
 - 14.10.2. On 8th September 1998 statement consisting of five pages from Mr Philip BEED Clinical Manager Daedalus Ward (Reference D143).
 - 14.10.3. On 9th September 1998 statement consisting of three pages from Ms Christine JOICE Staff Nurse Daedalus Ward (Reference D144).
 - 14.10.4. On 8th September 1998 statement consisting of two pages from Ms Monica PULFORD Enrolled Nurse Daedalus Ward (Reference D145).
 - 14.10.5. On 3rd September 1998 statement consisting of four pages from Ms Margaret COUCHMAN Staff Nurse Daedalus Ward (Reference D146).
- 14.11. A copy of the National Council for Hospice and Specialist Palliative Care Services paper entitled 'Ethical decision-making in palliative care'.
- 14.12. On 5th and 6th October 2000 I received from Hampshire Constabulary and subsequently read:-
 - 14.12.1. The records of the interviews conducted with Dr Anthea Everista Geredith LORD on 27th September 2000.
 - 14.12.2. During these interviews Dr LORD produced as listed in the Officer's Report by DC McNally the following documents:-

- 14.12.2.1. Drug Therapy Guidelines for subcutaneous fluid replacement as approved by the Elderly Medicine and Formulary & Medicines Group of Portsmouth Hospitals and Portsmouth Healthcare updated for 1998.
- 14.12.2.2. Consultants' Rota for August 1998 of the Department of Medicine for Elderly People (Ref: CI/28.7.98).
- 14.12.2.3. Memorandum from Mrs. L HUMPHREY of Portsmouth Health Care NHS Trust to Dr. LORD dated 17th December 1998 and headed 'Mrs. Richards deceased, Gosport War Memorial Hospital, 21st August, 1998.'
- 14.12.2.4. Letter from Dr R I REID, Medical Director of Portsmouth Health Care NHS Trust giving approval of study leave for Dr. LORD for the dates of 17/18 August 1998.
- 14.12.2.5. Consultants' Timetable of the Department of Medicine for Elderly People from 4.5.98 8.2.99.

Appendix B

Facts of the environment obtained from the statements of Mrs RICHARDS's daughters

- 15. Mrs MACKENZIE is the elder of Mrs RICHARDS's two daughters. It is noted that her sister, Mrs LACK, is a retired Registered General Nurse.
- 15.1. Mrs LACK retired in 1996 after 41 years continuously in the nursing profession. For 25 years prior to retirement she was involved in the care of elderly people. For 20 years prior to retiring she held supervisory and managerial positions in this field of nursing.
- 15.2. By July 1998, Mrs RICHARDS had been resident at the Glen Heathers Nursing Home for some four years. She had a past medical history of bilateral deafness for which she required two hearing aids (unfortunately these were lost while she was at the Glen Heathers Nursing Home). She had had operations for the removal of cataracts and required glasses (unfortunately these were also lost at the Glen Heathers Nursing Home).
- 15.3. Also by July 1998, Mrs RICHARDS had become increasingly forgetful and less able physically. She had had 17 falls documented at the Glen Heathers Nursing Home between 29th January 1998 and 29th July 1998.
 - 15.3.1. During this period Mrs MACKENZIE decided to meet and question her mother's general practitioner, Dr BASSETT. Mrs MACKENZIE had formed the opinion that the drugs Dr BASSETT was prescribing could contribute to her mother's confused mental state and deterioration of her physical health. One drug was Trazodone and the other was haloperidol. Following this meeting she sent him a copy of a book entitled *Toxic Psychiatry*.
 - 15.3.2. Dr BASSETT replied, in a hand-written letter, thanking Mrs MACKENZIE and stating '... I have a reputation in Lee [-on-Solent] of being somewhat sparing with 'mood' drugs and especially antibiotics. ... most drugs are prescribed with more caution these days. [paragraph] Hopefully we can continue to keep your Mother's drugs to a minimum!'
- 15.4. It is convenient to mention here that both Mrs MACKENZIE and Mrs LACK have registered serious concerns about the care given to their mother in the Glen Heathers Nursing Home.
 - 15.4.1. Jane PAGE, Principal Nursing Home Inspector, Portsmouth & S.E. Hants Health Authority investigated these concerns formally. On 11th August 1998, she made an unannounced visit to the Glen Heathers Nursing Home. She reported, on 26th August 1998, that 'From the written records obtained

- and discussions held, I can find no evidence to substantiate that Mrs RICHARDS did not receive appropriate care and medication.'
- 15.4.2. These concerns were discussed further by the Social Services Department at a meeting held on 23rd November 1998 when Mrs LACK was present. The conclusion was that 'There was no evidence of deliberate abuse [of Mrs RICHARDS] although there seemed to be problems of complacency in some of the care practices which needed review.... However, there was no evidence of malpractice by the Home.'
- 15.5. On 29th July 1998, while in the Glen Heathers Nursing Home, Mrs RICHARDS sustained a fracture of the neck of her right femur (thighbone). According to Mrs LACK her mother underwent a surgical operation on 30th July 1998 'following a discussion with the consultant who thought my mother should be given the chance to remain ambulant.'

15.6. Mrs LACK has also stated:-

- 15.6.1. 'My mother received a replacement hip, on her right side, and remained in the Haslar Hospital a further eleven days until Tuesday the 11th August 1998. [paragraph] I visited my mother every day during this period and, in my view, when taking into account the serious injury which she had sustained and the trauma she had suffered, my mother appeared to make a good recovery during this period.'
- 15.6.2. 'Prior to her discharge, and transfer to the Gosport War Memorial Hospital, my mother was responding to physiotherapy, able to walk a short distance with the aid of a zimmer frame and no longer required a catheter. Her medication had been reduced and she was able to recognise family members and make comments to us which made sense.'
- 15.6.3. 'She was with encouragement, eating and drinking naturally and as a result the drips, which had facilitated the provision of nourishment after the operation, had been removed.'
- 15.6.4. 'Significantly, my mother was no longer in need of pain relief. It was quite apparent, to me, that she was free of pain.'
- 15.6.5. 'Such was the extent of my mother's recovery that it was considered appropriate to discharge her and transfer her to the Gosport War Memorial Hospital where she was admitted to Daedalus Ward on Tuesday the 11th August 1998. This was the first occasion that my mother had been admitted to this particular hospital.'

- 15.7. On 12th August 1998, the day after her mother's admission to the Gosport War Memorial Hospital, Mrs LACK visited her mother there and has recorded '... I was rather surprised to discover that I could not rouse her [Mrs RICHARDS]. As she was unrousable she could not take nourishment or be kept hydrated. [paragraph] I enquired among the staff and I was told that my mother had been given the morphine based drug 'Oramorph' for pain. This also surprised me. When my mother had been discharged from the Haslar Hospital, the day before, she had not required pain relief for several days. [paragraph] I was distressed to observe my mother's deteriorated condition which significantly contrasted with the level of recovery which had been achieved following treatment at the Haslar hospital during the period after the surgical operation to replace her hip. [paragraph] I was told that my mother had been calling out, showing signs of being anxious, and it was believed that she was suffering pain. They did not investigate the possible cause. I consider it likely that she was in need of the toilet. ... One of the consequences of being rendered unrousable, by the effects of 'Oramorph', was that no fluids could be given to my mother and this, together with the abandonment of other forms of rehabilitation, would have served to inhibit or prevent the recovery process which had begun prior to her admission to the Gosport War Memorial Hospital.'
- 15.8. Mrs RICHARDS had a fall on 13th August 1998 (as described above). On the following morning (14th August 1998), Mrs LACK noted that while her mother was being taken to the X-ray department at the Gosport War Memorial Hospital 'She was still deeply under the effects of the 'Oramorph' drug.'
- 15.9. As described above Mrs RICHARDS was then transferred to the Royal Hospital Haslar for the reduction of her dislocated artificial hip. She was returned to the Gosport War Memorial Hospital on 17th August 1998 having been noted the previous day (16th August) by Mrs LACK [a nurse experienced in the care of elderly people] to be 'easily manageable'.
 - 15.9.1. In accepting that he would transfer Mrs RICHARDS to the Gosport War Memorial Hospital, Dr REID (consultant geriatrician) had stated that '... despite her dementia, she [Mrs RICHARDS] should be given the opportunity to try to re-mobilise.'
- 15.10. On visiting her mother at the Gosport War Memorial Hospital at about 1215 hours on 17th August 1998, Mrs LACK accompanied by her sister [Mrs MACKENZIE], found her mother to be screaming and in pain. The screaming ceased 'within minutes' when Mrs LACK and a registered general nurse repositioned Mrs Richards.
- 15.11. Subsequently, the X-ray at the Gosport War Memorial Hospital showed no fresh dislocation of the artificial hip.
- 15.12. Following this further X-ray, Mrs LACK told Dr BARTON that Haslar Hospital would be prepared to readmit her mother. Dr BARTON is reported to have '... felt that was

inappropriate.' Mrs LACK '... considered this was essential so that the 'cause' of my mother's pain could be treated and not simply the pain itself.'

- 15.12.1. Dr BARTON is stated to have said to Mrs LACK that, "..."It was not appropriate for a 91 year old, who had been through two operations, to go back to Haslar Hospital where she would not survive further surgery."
- 15.13. Mrs LACK states that, on 18th August 1998, the Ward Manager [Mr Philip BEED] explained to her and her sister that a syringe driver was going to be used. This was to ensure Mrs RICHARDS 'was pain free at all times' so that she would not suffer when washed, moved, or changed in the event she should become incontinent. Mrs LACK has also described in her contemporaneous notes (as well as in her Witness Statement, see below) that 'A little later Dr BARTON appeared and confirmed that a haematoma was present and that this [the use of a syringe driver] was the kindest way to treat my mother. She [Dr BARTON] also stated "And the next thing will be a chest infection." '.
 - 15.13.1. In her Witness Statement, Mrs LACK has recorded 'The outcome of the syringe driver was explained to my sister and I fully. Drawing on my experience as a nurse I [Mrs LACK] knew that the continuous use of morphine, as means of relieving her pain, could result in her death. She [Mrs RICHARDS] was, at the time, unconscious from the effects of previous doses of 'Oramorph'.... [paragraph] As result of seeing my mother in such great pain I was becoming quite distressed at this stage. My sister asked the Ward Manager, "Are we talking about euthanasia? It's illegal in this country you know." The Ward Manager replied, "Goodness, no, of course not." I was upset and said, "Just let her be pain free". [paragraph] The syringe driver was applied and my mother was catheterised to ease the nursing of her. She had not had anything by mouth since midday Monday 17th August 1998. [paragraph] A little later Dr BARTON [sic] appeared and confirmed that a haemetoma [sic] was present and that this was the kindest way to treat my mother. She also stated, "And the next thing will be a chest infection." [In her witness statement Mrs Mackenzie has stated that 'DR BARTON [sic] then said, "Well, of course, the next thing for you to expect is a chest infection".'][paragraph] I would like to clarify the issue of my 'agreement' to the syringe driver process. It was not a question, in my mind, of 'agreement'. [paragraph] I wanted my mother's pain to be relieved. I did not 'agree' to my mother being simply subjected to a course of pain relief treatment, at the Gosport War Memorial Hospital, which I knew would effectively prevent steps being taken to facilitate her recovery and would result in her death. [paragraph] I also wanted my mother to be transferred back to the Haslar Hospital where she had, on two occasions, undergone operations and recovered well. My mother was not, I knew, terminally ill and, with hindsight, perhaps I should have challenged Dr BARTON [sic] more strongly on this issue. [paragraph] In my severe distress I did not but I do believe that my failure to pursue the point more vigorously should not have

prevented Dr BARTON [sic] from initiating an alternative course of action to that which was taken, namely a referral back to the Haslar Hospital where my mother's condition could have been treated and where an offer had already been made to do so. [paragraph] I accept that my mother was unwell and that her physical, reserves had been depleted. However, she had, during the preceding days and weeks, demonstrated great courage and strength. I believe that she should have been given a further chance of recovery especially in the light of the fact that her condition had, it would seem likely. been aggravated by poor quality service and avoidable delay experienced whilst in the hands of those whose responsibly [responsibility] it was to care for her. [paragraph] My mother's bodily strength allowed her to survive a further 4 days using her reserves. She suffered kidney failure on 19th August and no further urine was passed. The same catheter remained in place until her death. [paragraph] Because the syringe driver was deemed to be essential following the night of several doses of pain relief my mother's condition gradually deteriorated during the next few days, as I knew it inevitably would, and she died on Friday the 21st August 1998.'

- 15.14. It is noted that Mrs LACK had made contemporaneous hand-written notes comprising five numbered pages. In her Witness Statement she records these '... are in the form of a basic chronology and I incorporated within them a series of questions which focused on particular areas of concern in respect of which I sought an explanation or clarification from the hospital authorities. Following presentation of my notes we were visited on the ward by Mrs Sue HUTCHINGS [sic] on 20.8.98.'
 - 15.14.1. Mrs LACK also made a further one page of contemporaneous hand-written notes. In these she states she was so appalled about her mother's condition, discomfort and severe pain that she visited Haslar Hospital at about lunchtime on 17th August 1998 to ask questions about her mother's condition before she [Mrs RICHARDS] had left the Haslar Hospital ward for her second transfer to Gosport War Memorial Hospital. She learned that, prior to her discharge from Haslar Hospital on 17th August 1998, her mother had been eating, drinking, using a commode and able to stand if aided. Mrs LACK also states in this contemporaneous record that 'On leaving the ward [at Haslar Hospital at about lunchtime on 17th August 1998] I bumped into the Dr [doctor] who had been in casualty theatre for my mothers [sic] second [sic] operation. He was with consultant when all the procedures were explained to me on Friday 14th [August 1998] He said "How's your mother". I explained the current position to him in detail. I told him that she was in severe pain since the transfer which had been undertaken a short time earlier. He said "We've had no referral. Get them to refer her back. We'll see her."
- 15.15. It is noted that a Discharge Letter from the Royal Hospital Haslar describes Mrs RICHARDS' condition on discharge on 17th August 1998 as "She can, however, mobilise fully weight bearing."

- 15.16. It is also noted that Mrs LACK has stated that she and her sister were constantly at the Gosport War Memorial Hospital, day and night, from 17th August 1998 until the time their mother died.
 - 15.16.1. Mrs MACKENZIE has stated that 'I stayed with my mother until very late that Tuesday night [18th August 1998]. it was past midnight, in fact, when my son arrived from London. As from the Wednesday night my sister also sat with me all night long and we both remained, continuously, until twenty past nine on the following Friday evening [21st August 1998] when my mother died. During that time Dr Barton [sic] did not visit my mother. I am quite certain about this because our mother was not left alone, in her room, at any time apart from when she was washed by the nursing staff. Either my sister or I, [sic] was with her throughout.'
 - 15.16.2. Mrs MACKENZIE has also stated that although she did not sign the contemporaneous notes made by Mrs LACK she '... was a party, at times, to the preparation process and where, on occasions, my sister has referred to 'I' in fact it could read 'we' as we were together when certain events occurred.'
 - 15.16.3. Mrs MACKENZIE continues 'It seems to me that she [Mrs RICHARDS] must have had considerable reserves of strength to enable her to survive from Monday until Friday, five days, when all she had was a diet of Diamorphine and no hydration whatsoever, apart from porridge, scrambled eggs and a drink, at the Royal Hospital Haslar, before transfer to the Gosport War Memorial Hospital.'

Appendix C

GLOSSARY

- Acetabulum is the name given to the two deep socket into which the head of the thigh bone (femur) fits at the hip joint.
- ADL [activities of daily living] are those physical activities of daily life necessary for normal human functioning and include getting up, washing, dressing, preparing a simple meal, etc.
- Analgesia is the relief of pain. This can be achieved by physical means including warmth and comfortable positioning as well as by the use of drugs. The aim is to keep patients pain free with minimal side effects from medication.
- Bronchopneumonia is inflammation of the lung caused by bacteria. Appropriate antibiotic therapy, based on the clinical situation and on microbiological studies, will result in complete recovery in the majority of patients.
- Co-codamol is a drug mixture consisting of paracetamol and codeine phosphate, which is used for the relief of mild to moderate pain.
- Cyclizine is a drug used to prevent nausea and vomiting, vertigo, and motion sickness.
- **Dementia** is the name given to a condition associated with the acquired loss of intellect, memory, and social functioning.
- Diamorphine, also known as heroin, is a powerful opioid analgesic.
- Haematoma is an accumulation of blood within the tissues, which clots to form a solid swelling.
- Haloperidol, a drug used in the treatment of psychoses including schizophrenia and mania and also for the short-term management of agitation, excitement, and violent or dangerously impulsive behaviour. Dosage for all indications should be individually determined and it is best initiated and titrated under close clinical supervision. For patients who are elderly the normal starting dose should be halved, followed by a gradual titration to achieve optimal response. It is not licensed for subcutaneous administration (see licensed below).
- Hemiarthroplasty is the surgical remodelling of a part of the hip joint whereby the bone end of the femur is replaced by a metal or plastic device to create a functioning joint.
- Hyoscine is a drug used to reduce secretions and it also provides a degree of amnesia and sedation, and has an anti-vomiting effect. Its side effects include drowsiness.
- Lactulose is a preparation taken by mouth to relieve constipation.

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A microgram is one millionth of a gram and is not to be confused with a milligram dosage of a drug, which is one thousand times larger.

Midazolam is a sedative drug about which there have been reports of respiratory depression. It has to be use with caution in elderly people. It is used for intravenous sedative cover for minor surgical procedures. It is also used for sedation by intravenous injection in critically ill patients in intensive care. It can be given intramuscularly. In the management of overdosage special attention should be paid to the respiratory and cardiovascular functions in intensive care. It is not licensed for subcutaneous administration (see licensed above).

Morphine is an opioid analgesic used to relieve severe pain.

Oramorph is a drug used in the treatment of chronic pain. It contains morphine and is in the form of a liquid. 10mls of Oramorph at a strength of 10mgs of morphine sulphate in 5mls of liquid is an appropriate first dose to give to a person in severe pain, which had not responded to other less potent, pain relieving drugs.

Respiratory depression is the impairment of breathing by drugs or mechanical means which leads to asphyxia and, if uncorrected, to death.

Subcutaneous means beneath the skin.

A syringe driver is a power driven device for pushing the plunger of a syringe forward at an accurately controlled rate. It is an aid to administering medicinal preparations in liquid form over much longer periods than could be achieved by injecting by hand. In this case the syringe driver used was a Sims Graseby MS 26 Daily rate syringe driver which operates over periods of 24-hours.

Tradazone is a drug used in the treatment of depressive illness, particularly when sedation is required.

Unlicensed medicines. In order to ensure that medicines are safe, effective and of suitable quality, they must have a product licence (now called a market authorisation) before being marketed in the United Kingdom. Unlicensed drugs are not licensed for use for any indication or age group. Licensing arrangements constrain pharmaceutical companies but not prescribers. The Medicines Act 1968 and European legislation make provision for doctors to use unlicensed medicines. Individual prescribers of unlicensed medicines, however, are always responsible for ensuring that there is adequate information to support the quality, efficacy, safety and intended use of a drug before using it.

A Zimmer frame is a lightweight, but sturdy, frame the patient can use for support to assist safe walking.

APPENDIX D

- 10. Texts used for reference have included:
- 10.1. Adam J. ABC of palliative care: The last 48 hours. *British Medical Journal* 1997; 315: 1600-1603.
 - 10.1.1. This paper is from the widely read, British Medical Journal which is published weekly and received by about 30,000 general practitioners and 45,000 hospital doctors in England and Wales. It records that treatment with opioids (viz. morphine and diamorphine) should be individually tailored, the effect reviewed, and the dose titrated accordingly.
- 10.2. ABPI Compendium of data sheets and summaries of product characteristics 1998-99: with the code of practice for the Pharmaceutical Industry. Datapharm Publications Limited, 12 Whitehall, London SW1A 2DY.
- 10.3. Breggin P R. Toxic psychiatry. Drugs and electroconvulsive therapy: the truth and the better alternatives. 1993. HarperCollins Publishers. London. pp. 578.
- 10.4. British Medical Association and the Royal Pharmaceutical Society of Great Britain. British National Formulary. Number 32 (September 1996). The Pharmaceutical Press. Oxford.
- 10.5. Letter from Clive Ward-Able (Medical and Healthcare Director) and Lee Neubauer BSc (Hons) (New Product Specialist), Roche Pharmaceuticals.
 - 10.5.1. This letter is reproduced as a supplement to this appendix (page S1) and reports that the product licence does not cover the administration of Hypnovel® (midazolam) by subcutaneous injection.
 - 10.5.2. Roche Pharmaceuticals. Hypnovel® [midazolam]. Summary of product characteristics.
- 10.6. Letter from Dr R J Donnelly, Medical Director of Janssen-Cilag Ltd.
 - 10.6.1. This letter is reproduced as a supplement to this appendix (page S2) and reports that HaldolTM decanoate (haloperidol) is not licensed for subcutaneous use.
- 10.7. Letter from Miss Jo Medlock, Manager of Medical Information and Pharmacovigilance, Norton Pharmaceuticals.

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- 10.7.1. This letter is reproduced as a supplement to this appendix (page S3) and reports that SerenaceTM (haloperidol) ampoules are not licensed for subcutaneous administration.
- 10.8. MeReC. Pain control in palliative care. MeReC Bulletin National Prescribing Centre. 1996; 7 (7); 25-28.
 - 10.8.1. MeReC is the abbreviation for the 'Medicines Resource Centre'. This bulletin is sent free to all general practitioners in England and Wales and also to NHS Hospital and Community Pharmacists. The list of those who receive this bulletin is updated every few weeks.
- 10.9. Sims Graseby Limited. MS 16A Syringe Driver. MS 26 Syringe Driver: Instruction manual. Sims Graseby Limited. 1998.

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