GLADYS RICHARDS

SUMMING UP

(1) Gladys Richards was a 91 years old lady who suffered from a dementing illness. She had lived in a nursing home since 1994.

(2) Over the years her illness had worsened and in 1998 a psycho-geriatrician had diagnosed her as having end stage dementia.

(3) Her decline ~~[illegible]~~ led to her suffering numerous falls in the nursing home. The final and most serious fall occurred on 29 July 1998 when she broke her right hip.

(4) She was taken to Haslar Hospital where the hip was repaired by hemi-arthroplasty. Whilst at Haslar she received pain control drugs from time to time - including intravenous Diamorphine.

(5) After the surgery she was felt to be sufficiently recovered for attempts to be made to see if she could be remobilised. At that time, she was weight bearing but could only move with a zimmer frame and support from 2 people and needed use of a hoist. She was transferred to Gosport War Memorial Hospital for possible remobilisation. The transfer took place on 11 August 1998.

(5 6) → OVER PAGE

(5b) She was taken to Daedalus Ward which was staffed by nurses. The only doctors serving the Ward were a consultant, Dr Lord, who did a round once a week – and a GP, Dr Baton, who as the Clinical Assistant was available at limited times ~~during~~ on weekdays, but not evenings and weekends. The staff on the ward and Dr Barton always had to work very hard to cope with the levels of work they had to deal with.

(6) On arrival at Gosport, she is assessed as having a Barthel Score of 3 which ~~sto~~ meant that she was ~~totally~~ almost totally dependent on others for all aspects of living.

(7) Dr Barton told me that she examined Mrs Richards and her impression was of a frail demented lady who might not be able to remobilise and who might not make a recovery at all whilst in ~~the~~ ~~ward~~. Daedelus Ward.

(8) In the notes Dr Barton recorded that at the time of the examination Mrs Richards was not obviously in pain but the doctor explained to me that that was a situation she suspected might not continue. As she was not available on the ward at all times, this was how she justified the drug presciptions she wrote for Mrs Richards on 11 August – to give the nursing staff the discretion to administer pain control without delay should Mrs Richards require it. She said that although anticipatory prescription wasn't ideal, it was a practical matter given the staffing arrangements and it was something she did frequently for patients like Mrs Richards.

(9) She also put in Mrs Richards' notes that she was happy for nursing staff to confirm her death. Again, she explained to me that was her standard practice because doctors weren't on the ward around the clock. She told me that it didn't mean she thought on 11 August that Mrs Richards would definitely die.

(10) Over the next couple of days, Mrs Richards mobilised to the extent that she could sit in a chair but required Oramorph and Haloperidol from time to time for pain and agitation.

(11) At about 13.30 on 13 August, Mrs Richards was found on the floor by nursing staff having apparently fallen out of her chair. No injury seems to have been apparent but later at around 19.30 ~~the~~ it was noticed that her right hip was rotated. She was given Oramorph for the pain that night and again the following morning when an X-ray revealed she had dislocated her repaired hip.

(12) She was transferred back to Haslar that day where the hip was manipulated back into place – a procedure, I was told, that would cause bruising and pain. Dr Barton said she had her doubts that Mrs Richards was well enough for it.

(13) Haslar discharged Mrs Richards back to Gosport on 17 August. Whilst the discharge letter says that she could mobilise and was weight bearing, Dr Barton told me that when she saw Mrs Richards back in Gosport that day, she saw someone in a very different condition from the way she was on first admission. She now thought Mrs Richards was unlikely to make a recovery ~~and was~~ at all and would probably die. At the time the doctor saw Mrs Richards, she had already been given Oramorph because on arrival ~~at G~~ from Haslar she was in great pain and distress due to the way she had been transferred. The evidence suggests to me that the mode of transfering her to the bed may ~~was~~ not have been correct and ~~was the immediate cause of Mrs Richard's plight.~~ was a cause of extreme pain to Mrs Richards.

(14) Mrs Richards went on to receive Oramorph on 5 occasions during the rest of the day and the early hours of 18 August.

(15) On the morning of 18 August, Dr Barton following updating from nursing staff, reached the conclusion that Mrs Richards was in great pain and distress that could only be effectively dealt ~~with~~ and Mrs Richards nursed by subcutaneous diamorphine, haloperidol and midazolam. Dr Barton's assessment of Mrs Richards confirmed to her that ~~she had~~ her view the previous day that the lady was in the process of dying was the correct one. ~~There was nothing that could be done to relieve her pain Mrs Richa~~

An X-ray apparently showed a large haematoma at Mrs Richard's surgery site. Dr Barton said nothing could have been done to treat the haematoma ~~other~~ by transferring her elsewhere and felt that the transfer itself could kill her - therefore she felt it inappropriate to transfer her.

(16) She felt the only course of action was to commence palliative care with Diamorphine, Haloperidol and Midazolan being administered via a syringe driver. Her view was that the dosages she prescribed were appropriate for the

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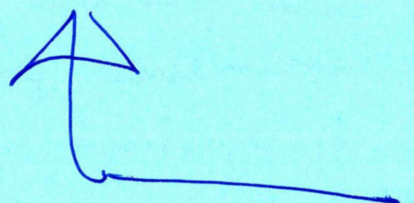
those deficiencies have again be highlighted at this inquest.



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circumstances.

(17) After commencement of the syringe driver, Mrs Richards was peaceful. Her daughter thought she was deeply unconscious, although this was challenged by other witnesses.

(18) When Dr Barton saw Mrs Richards again on ~~14 Febru~~ 19 August, she saw a further deterioration in her condition and assessed her as having developed a chest infection.

~~She cont~~

(19) Mrs Richards continued to decline – this was noticed by Dr Barton on 20 August and 21 August. The signs of bronchopneumonia continued.

(20) Mrs Richards died at 21.20 hours on the evening of 21 August.

(21) On 24 August, Dr Barton certified ~~the~~ Mrs Richard's cause of death as Bronchopneumonia.

(22) The records of assessments of Mrs Richards and of her treatment and progress at Gosport ~~was~~ were sketchy. Dr Barton explained this as being due to lack of time – ~~[illegible]~~ actual care of the patients took priority for both her and the nurses.

(23) This poor record keeping has been scrutinised and censured elsewhere and I do not need to comment further upon it – other than to say

(24) However, in one area at least, the records appear to be complete and that is in relation to when and how much medication was given to Mrs Richards. The witnesses asked about this all appeared to appreciate the need for the administration of drugs to follow correct procedures and to be recorded. In answer to the recollections of both Mrs Richards' daughters that their mother had been given 2 injections to relieve pain on the afternoon of 17 August, the witnesses were adamant that this had not happened and stressed that if the injections had been given, they would have been properly recorded – not only in the notes where there was nothing about them nor in the Controlled Drugs Book.

(25) I heard evidence from 2 medical experts –

- Professor Ferner, a professor of clinical pharmacology and a registered toxicologist
- Professor Black, a geriatrician

(26) Professor Ferner's opinion was that it was most likely that the subcutaneous administration of Diamorphine, Haloperidol and Midazolam hastened Mrs Richards' death. Diamorphine could cause respiratory depression which can lead to chest infections. Similarly, sedation could

Mehigan – nothing further to say.

reduce her ability to swallow which could lead to kidney failure as was suggested by Mrs Richards ceasing to produce urine.

(27) Professor Black took a more holistic approach in his evidence and considered Mrs Richards' death as being ~~[illegible]~~ on the balance of probabilities due to a more complex – although common – set of circumstances. Factors that had all played a part were her age, frailty and end stage dementia taken together with the trauma sustained in the falls and the corrective surgery. Added to this was her immobility and he agreed with Prof Ferner that the analgesics and sedatives also made a contribution along with these other factors.

OVER

G. Sub's (cont'd)

Drugs book examined by police & no discrep.
No evid of dose rec'd ∴ how can they be
contributory to death ?

Jenkins Sub's

Short form or Narrative down to
Coroner.
4 ques of R.36.
How = causal mechanisms of death & ∴
must incl care actually provided but
doesn't incl notekeeping.
Did care play a role or inapprop ? Be
way to pay attention to inadeq notes
to say no justific — Melugun does this.
Oram on 1st admission. Evid on syringe
driver. Syr. dr. drugs not criticised by Prof B.
Neglect wld have to be gr. failure to provide
basic care. View what was done in that
light.

(28) Having considered all of the evidence before me and listening to the legal submissions which have been made, I have reached the conclusion that I should answer the question of how Mrs Richards died by recording a Narrative Verdict.

(29) Before I do so, I have to remind myself that the law prevents me from recording a verdict which purports to determine the question of any named person for the death or any question of civil liability for the death.

(30) My verdict must be limited to answering the questions of who has died, when and where they've died - and how they've died - in other words how they have met their death.

(31) So, I wish to record my verdict on Mrs Richards' death in this manner -

(OVER)

Green Subs

No sub's on Neglect or Narative.

Sub's on Unlawful Killing – wld resist any evid of gr. neglig by nursing staff –

Drugs 13/8 → not excessive. Evid too tenuous to support U. Killing.

UK = Beyond reas doubt, evid must prove this. Evid M relies on is far too tenuous –

① Prof F Report

Para 97 – Not criticising measures to make pain free.

F = No evid in notes that R didn't swallow. On balance of prob's diam hastened death. No record = No justific (~~Fr~~) – He ack'd that poor note taking may not record the decis which evid heard.

All his concl's on balance of probs, but not beyond reas doubt.

② Alleged injections by Beed on 17/8 – Neither M or O'B knew what drug was or what dose was. No inj's recorded + Beed denies giving any injections. Inconsist's in M/O'B evid, not mentioned by O'B in police statement.

Black

Black / Meh

Rehab not the same as cure.
Dr B resp for day to day total care,
to deal with whatever they're faced with.

200mg a fatal dose but if someone
has had it before it wldn't be.

Wessex guidelines in general use then.
Protocols only getting off the ground then.
Things very different then.
(Prof B. sticks to his report views
throughout his answers)

Bl / O'B (Bermingham)

B | Green

Para 8 of report (see p.45 - 48 of nursing notes)

Para 3.8 - no pain mentioned prior to disloc.

Para 4.9 - poss causes for fall on 13/8 - Contrib of Oram? Last dose ~~at~~ early on morning of 12/8. I feel in someone severely dem'd this can affect their mental state, this is poss. if it had caused agitation ~~it~~ can lead to a fall.

Para 4.3 (regarding falls) - late diag of fall, reasons for. Cld this lead to late diag of disloc? I don't know.

Correct dose = one which relieves pain and prevents break thru' pain. Some evid of break thru' pain = some evid dosage was just enough.

Cld she get tolerance of side effects of morphine? Yes I've already said this.

∴ doses need to be increased.

B/Green (con'td)

Morph not more dangerous because of mode of deliv, the dose is.

B/ Jenkins

~~[illegible]~~ Notes are very thin. Do records set out plans + what has happened?. Where notes are less than full, I can't fill in the gaps re: justific.
GMC says dr's shld record things properly. Dr B's job descip incl. this.