Field Fisher Waterhouse

GENERAL MEDICAL COUNCIL

-and-

DR BARTON

GLADYS RICHARDS

FFW/89/03

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GENERAL MEDICAL COUNCIL

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Index to Gladys Richards' Files

File 1

1. Medical Report prepared by Professor G A Ford dated 12 December 2001.

2. Medical Report prepared by Professor Brian Livesley dated 10 July 2001.

3. Statement of Dr Jane Barton.

File 2

4. Witness Statements given to Hampshire Constabulary.

   (a) Ian Piper dated 21 November 2002 at 11:21.

   (b) Ian Piper dated 21 November 2002 at 12:13.

   (c) Gillian Mackenzie dated 27 April 1999.

   (d) Gillian Mackenzie dated 17 November 1999 at 11:45.

   (e) Gillian Mackenzie dated 17 November 1999 at 12:46.

   (f) Gillian Mackenzie dated 6 March 2000.

   (g) Mrs Gillian Mackenzie dated 6 March 2000.

   (h) Philip James Beed dated 24 July 2000 at 11:00.

   (i) Philip James Beed dated 24 July 2000 at 12:14.

   (j) Philip James Beed dated 24 July 2000 at 14:12.

   (k) Philip James Beed dated 24 July 2000 at 14:58.

   (l) Philip James Beed dated 24 July 2000 at 15:52.

(m) Sylvia Roberta Giffin dated 6 June 2000.

(n) Sylvia Roberta Giffin dated 19 June 2000 at 11:17.

(o) Sylvia Roberta Giffin dated 19 June 2000 at 12:07.

(p) Dr Jane Ann Barton dated 25 July 2000 at 11:10.

(q) Dr Jane Ann Barton dated 25 July 2000 at 11:59.

(r) Catherine Marjoram dated 1 June 2000 at 15:02.

(s) Catherine Marjoram dated 20 June 2000 at 14:14.

(t) Margaret Rose Couchman dated 29 June 2000 at 10:26.

(u) Margaret Rose Couchman dated 29 June 2000 at 11:17.

(v) Anita Tubbritt dated 28 June 2000 at 10:19.

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(w) Christina Ann Tyler dated 10 July 2000 at 11:06.

(x) Christina Ann Tyler dated 10 July 2000 at 11:54.

(y) Fiona Walker dated 20 June 2000 at 10:39.

(z) Kathleen Mary Wallington dated 3 July 2000 at 10:55.

(aa) Monica Catherine Pulford dated 19 June 2000 at 14:40.

(bb) Margaret Joan Perkins dated 26 June 2000 at 18:05.

(cc) Jean Kathleen Moss dated 5 July 2000 at 11:00.

(dd) Althea Eueresta Geredith Lord dated 27 September 2000 at 14:14.

(ee) Althea Eueresta Geredith Lord dated 27 September 2000 at 15:19.

(ff) David Andrew Black dated 24 July 2005.

(gg) David Andrew Black dated 10 August 2005.

(hh) Janice Rix dated 11 August 2004.

(ii) Jill Stephanie Maureen Chappell dated 17 July 2003.

(jj) Katherine Wilde dated 31 July 2000.

(kk) Minh Rushton dated July 2000.

(ll) Geraldine McCarthy dated 7 August 2000.

(mm) Wendy Edgar dated July 2000.

(nn) Marion Berry dated 2 August 2000.

(oo) Michael James Edmonson dated 7 July 2000.

(pp) Martin Dean Tanner dated 28 June 2000.

(qq) Philip James Warren dated 24 May 2000.

(rr) Richard Ian Reid dated 7 June 2000.

(ss) Lesley Forbes Humphrey dated 27 January 2000.

(tt) Lesley Forbes Humphrey dated 26 May 2000.

(uu) Anne Funnell dated 25 February 2000.

(vv) Lesley Frances Lack dated 31 January 2000.

(ww) Lesley Frances Richards dated 11 August 2004.

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
Consultant Physician, Freeman Hospital
Newcastle upon Tyne
Professor of Pharmacology of Old Age, University of Newcastle upon Tyne

For: **Hampshire Constabulary**

Date: **12th December 2001**

Contents

Introduction and Remit of the Report

8.1 I am Professor of Pharmacology of Old Age in the Wolfson Unit of Clinical Pharmacology at the University of Newcastle upon Tyne, and a Consultant Physician in Clinical Pharmacology at Freeman Hospital. I am a Doctor of Medicine and care for patients with acute medical problems, acute poisoning and stroke. I have trained and am accredited on the Specialist Register in Geriatric Medicine, Clinical Pharmacology and Therapeutics and General Internal Medicine. I provide medical advice and support to the Regional Drugs and Therapeutics Centre Regional National Poisons Information Service. I was previously clinical head of the Freeman Hospital Care of the Elderly Service and have headed the Freeman Hospital Stroke Service since 1993. I undertake research into the effects of drugs in older people. I am co-editor of the book 'Drugs and the Older Population' and in 2000 was awarded the William B Abrams award for outstanding contributions to Geriatric Clinical Pharmacology by the American Society of Clinical Pharmacology and Therapeutics. I am a Fellow of the Royal College of Physicians and have practised as a Consultant Physician for nine years.

8.2 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 DS J James 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

- 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 July 0150h 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 DC Colvin and DC McNally). 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 DC McNally and DC Colvin describes Daedalus ward as "*Back in '98 .. Daedalus was a 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 DS Sackman and DC Colvin, 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 subsequent sub-optimal care.

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 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 DC Colvin and DC McNally 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 post-mortem, 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

3.1 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. TCI Dyad today –aserbine for sacral ulcer – nurse on side – high protein diet – oramorph prn 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 20mg/24hr, midazolam 20mg/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 100mg/24hr of great concern. I would anticipate that this dose of midazolam administered with 80mg/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.

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 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

4.1 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*".

5.2 On 7th October the notes record he was "*not keen on residential home and 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 Code A Code A 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, Code A 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
18 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

6.1 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 Dr Harris 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)

28 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

8.1 Morphine is a potent opiate analgesic considered by many to the 'drug of 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

8.1 The BNF states 'oral medication is usually satisfactory unless there is severe 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 analgesics (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 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

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)

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.

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.

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 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?'

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 co-ordinator [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 August1998. 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 11th – 14th 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 11th – 14th 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 21st August 1998.

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 21st August 1998.

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 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

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, 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 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.

5. *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 Haldol™ 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 Serenace™ (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

I, Brian Livesley, qualified MB, ChB (Leeds) in 1960.
My principal additional qualifications are MD (London) 1979, FRCP (London) 1989.

From 1961-69, I held a series of clinical training and teaching posts through all hospital medical grades to senior medical registrar level at University and District Hospitals in Leeds, Manchester and Liverpool in which I gained a wide range of general medical expertise.

At the beginning of my medical career during 1961, I was also trained in the management of diabetic patients in Leeds by Professor (later Sir) Ronald Tunbridge. For five years (1963-67), I held a regular weekly diabetic out-patient clinic in Manchester (two diabetic clinics each week during 1963-65) being also responsible for the acute and follow-up management of newly presenting diabetic patients as well as having a full range of general medical experience.

For four years (1969-72), I was Harvey Research Fellow in cardiology at King's College Hospital, London, where I developed original research in electrocardiographic, cardiac pacing, and metabolic techniques for the study of ischaemic heart disease. This also involved extensive follow-up studies over a period of more than six years. The several and separate aspects of this work were published in internationally reputable professional journals and now form part of the corpus of present day knowledge in cardiology. My continuing interest in this area led me to specialise in geriatric medicine with some emphasis on cardiology in elderly people.

I have been a consultant physician since 1973 and am entered in the General Medical Council's Principal List as a specialist in both General Medicine and Geriatric Medicine.

In 1987, I was appointed against open competition to a Foundation Chair as the University of London's Professor in the Care of the Elderly based at Charing Cross and Westminster Medical School (now the Imperial College School of Medicine) and as Honorary Consultant Physician.

I am in active clinical practice at the Chelsea & Westminster Hospital, London, where I head up a busy clinical department consisting of three consultant-led medical teams. These are all routinely involved in the emergency medical admissions and follow-up management of adults of all ages including those with diabetes mellitus, cardiac, respiratory, and skeletal diseases. During the last two years I have developed one other team that is providing a palliative care service for non-cancer patients.

Since 1969 I have taught not only undergraduate and postgraduate medical students, but also by invitation have lectured (throughout the United Kingdom, Europe, and elsewhere) to a wide range of other groups—professional and lay. I have also initiated and led courses teaching and appraising senior medical teachers. For fifteen years (1980-94), I served as a clinical examiner for the Final MB degree at the University of London—latterly (1990-94) as a senior clinical examiner. For six years (1987-93), I also examined in Medicine for the Worshipful Society of Apothecaries of London. For seven years (1986-93), I was Royal College of Physicians of London Examiner for the Diploma of Geriatric Medicine; and, for two years (1994-96) was an appointed Member of the United Examining Board for England and Scotland. In addition, I have examined externally for the degrees of BPharm and PhD. During 1998, 1999, & 2000 I have been an invited external clinical examiner for the Final MB degree at the Royal Free and

University College London Medical School where by recent invitation I will examine the candidates being considered for a Distinction in 2001.

In 1991, by invitation, I addressed a House of Lords group on issues relating to the clinical management of elderly people.

In 1992, I was one of a team at the Royal College of Physicians who contributed to the College's publication entitled, 'High quality long-term care for elderly people.'

From 1983-1995 I was a Justice of the Peace for the SE London Commission of the Peace having to stand down following a invitation in 1995 to head up a comprehensive review of the care provided in a 150-bedded nursing home. In 1996 all 16 recommendations in the resulting 40,000-word report were accepted and acted upon by the commissioning Health Agency (1). Also in 1996, I gave invited evidence on this topic to a Health Committee in the House of Commons (2).

In 1999 and again in 2000, the King's Fund in London identified the work in my clinical department as a national model for the care of elderly people.

In July 2000, I was the only clinician to give a presentation by invitation at a meeting on "Emerging Intermediate Care Strategy — 'Leading edge' Practice" held at the Royal College of Surgeons of England, London. This was well received and repeated by invitation in the North of England in November 2000.

During 1999 and 2000 I was working with the British Medical Association's Ethics department on the topics of 'dying as a diagnosis' and 'the appropriate care of the dying'. In addition, I have recently chaired a medico-legal group within my NHS Hospital Trust and produced a report on 'Guidelines for the artificial nutrition of patients affected by strokes'. My clinical, teaching, and research work on the management of dying patients extends over the last twenty five years and I was a leader of the concept that 'dying should be a recognised diagnosis' to allow for the appropriate palliative care of patients dying from non-cancer conditions. More recently I have established an original palliative care service for non-cancer patients in my own department at the Chelsea & Westminster hospital where we are pursuing research in this topic.

My over 120 publications include several monographs, many peer-reviewed research investigations into clinical, scientific, social, historical, and educational problems of medicine in our ageing society, editorials and leading articles by invitation of professional journals, and, in addition by invitation, more than 100 standard and extended book reviews. My peer-reviewed publications also include those on the clinical management of dying patients.

References as numbered above:

1. Livesley B, Ellington S. Report on the independent comprehensive review of the care of elderly people at St. Christopher's Nursing Home, Hatfield. East and North Hertfordshire Health Authority, 1996. (by invitation)

2. Livesley B. Memorandum of recommendations and evidence submitted to the Health Committee on long-term care provision and funding. Volume II; pp. 114-22. London: HMSO, 1996. (by invitation)

signed ... Code A ... date 10th July 2001

BRIAN LIVESLEY

POLICE STATEMENT OF DR JANE BARTON

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

I am happy for nursing staff to confirm death

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

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

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

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

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

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

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

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

"*14.8.98* *Dear S. Cdr Spalding*
Further to our telephone conversation
thank you for seeing this unfortunate
lady who slipped from her chair at
1.30 p.m. yesterday- and appears to have
dislocated her R hip
hemi arthroplasty was done on 30.7.98
I am sending X-Rays across
she has had 7.5 mls of 10 mg/ in 5 ml oramorph
at midday
Many thanks"

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

37. On the next working day, Monday , 24th of August, I discussed the case with the Coroner's Officer, a police officer at Cosham Police Station. I informed him that Mrs Richards had sustained a fractured neck of femur on the ~~13th August~~ 8th July and was subsequently operated on at RHH. I would have told him of the dislocation and the fact that she had returned to RHH and back to our care and had died on 21st August; in my view of bronchopneumonia. The Coroners Officer was happy that no further investigation was required and I signed the death certificate putting bronchopneumonia as the cause of death. I believe that this was the cause of death in all the circumstances.

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

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

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