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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.

Medical terms and explanations

2. I have indicated any medical terms in **bold type**. I have defined these terms in a glossary in Appendix 5. I have also included, in a separate section, references to published works to which I refer in my report; extracts of these are included in Appendix 6.

Information relating to Mrs Gladys Richards (deceased)

3. Mrs Gladys Mable Richards (née Beech) was born on Code A and died on 21st August 1998 aged 91 years.

3.1. Mrs Richards has two daughters who are witnesses in this case. They are Mrs Gillian Mackenzie (the elder daughter) and Mrs Lesley Frances Lack.

Chronology

4. Mrs Richards had a past medical history of bilateral deafness for which she required a hearing aid and had had operations for the removal of cataracts and required glasses.

4.1. At the beginning of 1998, she had become increasingly forgetful and less able physically. She had developed increasing confusion and had a six months history of falls when, in July 1998, she became resident at the Glen Heathers Nursing Home.

4.2. On 29th July 1998, following a fracture of the neck of her right femur, Mrs Richards was transferred to the Royal Hospital Haslar, Gosport, and had a right cemented hemi-arthroplasty [an artificial hip joint inserted].

4.2.1. She made satisfactory progress and it is noted that after this procedure Mrs Richards became 'fully weight bearing, walking with the aid of two nurses and a Zimmer frame.'

4.2.2. On 5th August 1998, Dr Reid [consultant geriatrician] stated that despite Mrs Richards' dementia she should be given the opportunity to try to re-mobilise. He arranged for her transfer to Gosport Memorial Hospital.

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4.3. On 11th August 1998, Mrs Richards was transferred to Daedalus ward at the Gosport War Memorial Hospital. Here it was noted in the nursing records that '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.'

4.4. Also on 11th August 1998, Dr Barton wrote by hand in the medical records '... 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 ... I am happy for nursing staff to confirm death.'

4.5. On the 13th August 1998, Mrs Richards fell on the ward and was found to have dislocated her implanted hip joint when she was x-rayed the following morning.

4.5.1. At this time Dr Barton recorded '... very sensitive to oramorph. ... Is this lady well enough for another surgical procedure?'

4.6. Mrs Richards was transferred back to the Royal Hospital, Haslar and her dislocation corrected using traction assisted by intravenous midazolam with monitoring of her cardiovascular and respiratory systems. She was then admitted the Royal Hospital for 48 hours observation.

4.6.1. 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. It was also recorded that no follow-up was required unless complications developed.

4.7. She was returned to Daedalus ward in the Gosport War Memorial hospital later that day but in a very distressed state. She had been transferred on a sheet and not on a canvas stretcher. She was given oramorph and x-rayed again that afternoon. No further dislocation was noted.

4.8. There is no evidence that after her return to Daedalus ward on 17th August 1998, and until her death on 21st August 1998, Mrs Richards was kept hydrated or fed.

4.9. Dr Barton reviewed her on the morning of 18th August 1998 and prescribed the use of drugs administered subcutaneously through a syringe driver for pain control. These drugs were Medazolam, diamorphine, haloperidol (? via syringe driver), and hyoscine in doses described later.

4.10. There is no evidence that, after the morning of 18th August 1998 and until her death on 21st August 1998, Dr Barton or any other medical practitioner reviewed Mrs Richards' response to her medication with a view to adjusting its dosage.

4.11. There is no evidence that, after the morning of 18th August 1998 and until her death on 21st August 1998, any member of the nursing staff reviewed Mrs Richards' response to her medication with a view to reducing its dosage.

4.12. There is evidence that Mrs Richards was repeatedly given subcutaneously by syringe driver unmonitored doses of the drugs described above from 18th August 1998 until she died on 21st August 1998.

4.13. Apart from the times when the nurses cleaned Mrs Richards, her daughters were present almost continuously while she became unconscious and until she died on 21st August 1998. The cause of her death was given as 'Bronchopneumonia'.

4.14. There is no contemporaneous clinical evidence that Mrs Richards died as a result of bronchopneumonia. Her body was cremated.

Relevant aspects of Mrs Richards' previous medical history

5. 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 a hearing aid (unfortunately this was 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).

5.1. Also by July 1998, Mrs Richards had become increasingly forgetful and less able physically. She had 17 falls documented at the Glen Heathers Nursing Home between 29th January 1998 and 11th August 1998.

5.1.1. 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*.

5.1.2. 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!'

5.2. 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.

5.2.1. Jane Page, Principal Nursing Home Inspector, 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.'

5.2.2. 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.'

5.3. On 29th July 1998, while in the Glen Heathers Nursing Home, Mrs Richards sustained a fracture of the neck of her right femur (thigh bone).

Clinical events following Mrs Richards' hip fracture

6. Mr Richards was transferred to the Royal Hospital Haslar, Gosport, where on 29th July 1998 at 2300 hours she was admitted. On 30th July 1998, she had a right cemented hemi-arthroplasty [an artificial hip joint inserted]. This was apparently performed under local anaesthesia.

6.1.1. On 3rd August 1998 it was noted 'All well. Sitting out early mobilization'.

6.2. 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.'

6.2.1. 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.'

6.3. 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:-

6.3.1. After this procedure 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.'

6.4. On 11th August 1998, Mrs Richards was transferred to Daedalus ward at the Gosport War Memorial Hospital.

6.4.1. There is an unsigned 'Summary' record which is apparently a Nursing record and this states:-

6.4.1.1. '11-8-98 Addmitted [sic] from E6 Ward Royal Hospital Haslar, into a continuing care. 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....'

6.4.2. 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.'

6.4.3. 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]'

6.5. ??[initials]B [subsequently identified as Dr Barton] has written in the medical cases 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 ... I am happy for nursing staff to confirm death.'

6.6. 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.'

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6.7. The Nursing Contact Record at Daedalus ward continues:-

6.7.1. '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]'

6.8. 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?'

6.9. Mrs Richards was transferred back to the Royal Hospital, Haslar and 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.' She was then admitted the Royal Hospital for 48 hours observation.

6.10. The Nursing Contact Record at Daedalus ward in the Gosport War Memorial hospital continues:-

6.10.1. '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.'

6.11. On 17th August 1998 it was 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.'

6.12. The Nursing Contact Record at Daedalus ward in the Gosport War Memorial hospital continues:-

6.12.1. 17/8/98 11.48 [hours] Returned from R.N.Haslar [Royal Naval hospital Haslar], patient very distressed appears to be in pain. [Initialled signature] [then, in different handwriting an arrowed insertion] No canvas under patient [paragraph] patient – transferred on sheet by crew [by the people who transferred her from Haslar hospital back to Daedalus ward] To remain in straight knee splint for 4/52 [four weeks] For pillow between legs at night (abduction) No follow-up unless complications [signature].'.

6.12.2. '17.8.98 1305 [hours] In pain and distress – agreed with daughter to give her mother oromorph [sic] [oramorph, a morphine preparation that can be given orally] 2.5 mg [milligrams] in 5 mls [millilitres]. [paragraph] Daughter

reports surgeon to say her mother MUST [sic] not be left in pain if dislocation occurs again. Dr Barton contacted and has ordered an Xray. [signature]'

6.12.3. '[17.8.98] pm Hip Xrayed at 1545. Films seen by Dr Peters & radiologist & no dislocation seen. [paragraph] For pain control overnight & review by Dr Barton mane [in the morning]. [initialled signature]'

6.12.3.1. This radiograph was reported to show 'RIGHT HIP: The right hemiarthroplasty is relocated in the acetabulum.'

6.13. Mrs Lack has stated that she told Dr Barton and the Ward Manager that Haslar hospital was prepared to re-admit her mother. Dr Barton is reported by Mrs Lack to have stated "It is not appropriate for a 91 year old, who has been through two operations, to go back to Haslar Hospital where she would not survive further surgery."

Mrs Richards management from 18th August 1998 until her death

7. Mrs Lack states that, on 18th August 1998, the Ward Manager explained to her and her sister that a syringe driver was going to be used to ensure Mrs Richards 'was pain free at all times'. Mrs Lack has also stated that 'A little later Dr BARTON [sic] 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." '.

7.1. The Nursing Contact Record at Daedalus ward in the Gosport War Memorial hospital continues:-

7.1.1. '18/8/98 am [meaning, at some time in the morning] Reviewed by Dr Barton. [paragraph] For pain control via syringe driver. [paragraph] 1115 [hours] Treatment discussed with both daughters. They agree [Mrs Lack disagrees with this statement] to use of syringe driver to control pain & [and] allow nursing care to be given. [paragraph] 1145 [hours] Syringe driver diamorphine 40mg, Haloperidol 5mg, Medozalom [probably meaning 'midazolam'] 20 mg commenced.'

7.1.2. '18/8/98 20.00 [hours] Patient remained peaceful and sleeping. Reacted to pain when being moved – this was pain on both legs. [paragraph] Daughter quite upset and angry about her Mother's condition, but appears happy that she is pain free at present. [signature] [paragraph] 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]'

7.1.3. '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]'

7.1.4. It is noted that there is no continuing Nurse Contact Record for the 20th August 1998.

7.1.5. '21/8/98 12.13 [hours] Patient's [Mrs Richards] overall condition deteriorating, medication keeping her comfortable. Daughters visited during the morning. [signature]'

7.1.6. '21-8-98 Condition poor. Pronounced death at 21-20 hrs [hours] by S/N [staff nurse] Sylvia Roberts [then an illegible word] Relatives present (2 daughters) for cremation [signature]'

7.2. The Nursing Care Plan records state:-

7.2.1. '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.'

7.2.2. '13.8.98 oromorph at 2100 [hours] Slept well [initialled signature] [paragraph] For Xray tomorrow morning [initialled signature]'

7.2.3. '14.8.98 Same pain in rt[right] leg / ?[query] hip this am. [initialled signature]'

7.2.4. 'Re-admitted 17/8/98'

7.2.5. '17.8.98 **Oromorph** 10mg/5ml at present.'

7.2.6. '18.8.98 Now has a syringe driver with 40mgs **Diamorphine** – comfortable. Daughters stayed. [initialled signature]'

7.2.7. 'Daughters stayed with Gladys [Mrs Richards] overnight. [initialled signature]'

7.2.8. There is no record of continuance of the Nursing Care Plan for 20th and 21st August 1998.

7.2.9. Moreover, after Mrs Richards had been readmitted to Daedalus ward on 17th August 1998, in the patient Nursing Care Plan for 'Nutrition' there is no record between 17th and 21st August1998. On 21st August the record states 'no food taken [initialled signature]'.

7.2.10. 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]'

7.2.11. The Nursing Care Plan for 'Personal Hygiene' states:-

7.2.11.1. '18.8.98 Complete Bed Bath given plus oral [Signature] Hygiene [second signature]'

7.2.11.2. '18.8.98 Night: oral care given frequently'

7.2.11.3. '19.8.98 Nightie changed & washed, repositioned. Apparently pain free during care [initialled signature]'

7.2.11.4. It is noted that there is no record of Mrs Richards being attended to for 'Personal Hygiene' on 20th August 1998.

7.2.11.5. '21.9.98 General care and oral hygiene given [initialled signature]'

7.3. From 17th August 1998, the drugs prescribed for Mrs Richards are described in the section below, which is entitled 'Drugs prescribed for Mrs Richards at Gosport War Memorial hospital'.

Information from the statements of Mrs Richards' daughters

8. Mrs Mackenzie is the elder of the two. It is noted that her sister, Mrs Lack, is a retired Registered General Nurse.

8.1. 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.

8.2. On 12th August 1998, the day after her mother's admission to the Gosport War Memorial hospital, Mrs Lack visited her mother there and in her Witness Statement 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.'

8.3. Mrs Richards had a fall on 13th August 1998 (as noted 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.

8.4. 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'.

8.4.1. In accepting to admit 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.'

8.5. 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 when Mrs Lack and a registered general nurse repositioned Mrs Richards.

8.6. Subsequently, the X-ray at the Gosport War Memorial Hospital showed no fresh dislocation of the artificial hip.

8.7. 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.'

8.7.1. 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." '

8.8. On 18th August 1998, Mrs Lack was told [by the Ward Manager, Mr Philip Beed] that while her mother had undergone a peaceful night she had, however, developed a massive haematoma in the vicinity of the operation site which was causing her severe pain. It was further explained by Mr Beed that the plan of management was to use a syringe driver 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.

8.8.1. 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 haematoma 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.'

8.9. 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 on 20.8.98.'

8.9.1. 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 Halsar 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 Halsar 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 "Hows your mother". I explained in detail. He said we've had no referral. Get them to refer her back. We'll see her. I told him she was in severe pain since the transfer.'

8.10. 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."

8.11. 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.

8.11.1. 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.'

8.11.2. Mrs Mackenzie has also stated that although she did not signed 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.'

8.11.3. 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.'

8.12. Lesley Humphrey, Quality Manager for Portsmouth Health Care Trust, in her statement dated 27th January 2000, states that 'The nursing care provided [at Gosport War Memorial Hospital] is non acute, for instance intravenous fluids would rarely be given. Subcutaneous fluids can be given, as can fluids and liquid feeds via a naso-gastric tube.'

Drugs prescribed for Mrs Richards at Gosport War Memorial hospital

9. On 11th August 1998, Dr Barton wrote an 'As required prescription' of certain drugs for Mrs Richards. These consisted of:-

9.1. Oramorph 10mgs in 5mls to be given orally four hourly.

9.1.1. On the Administration Record these doses are recorded as being given twice on 11th August 1998 (at 1015 [?1215] and 1145 [?pm]), once on 12th August (at 0615), once on 13th August (at 2050), once on 14th August (at 1150), four times on 17th August (at 1300, ????[illegible], 1645, and 2030), and on 18th August 1998 at 01230[sic] and [?]0415). It is noted that these doses appear to have been taken from the Ward's stock and not all dose times appear to use the 24-hour clock.

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9.2. Diamorphine at a dose range of 20 – 200 mg to be given subcutaneously in 24 hours.

9.2.1. None of this diamorphine prescription is recorded on the Administration Record as having been given between 11th – 14th August inclusive but this drug appears to have been available from the ward's stock.

9.3. Hyoscine at a dose range of 200 – 800 mcg [micrograms] to be given subcutaneously in 24 hours.

9.3.1. None of this hyoscine prescription is recorded on the Administration Record as having been given between 11th – 14th August inclusive but this drug appears to have been available from the Ward's stock.

9.4. midazolam at a dose range of 20-80 mgs to be given subcutaneously in 24 hours.

9.4.1. None of this midazolam prescription is recorded on the Administration Record as having been given between 11th – 14th August inclusive but this drug appears to have been available from the ward's stock.

9.5. In addition, on 13th August 1998, Mrs Richards was prescribed haloperidol 2mgs in 1ml to be administered as required at a dose of 2.5ml [this figure has been altered and also reads 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.

9.6. Dr Barton also wrote a 'Regular prescription' of certain drugs for Mrs Richards. These consisted of:-

9.6.1. On 11th August 1998, **Lactulose** to be given orally at a dose of 10mls twice daily.

9.6.1.1. This drug was administered once on 11th, once on 12th, twice on 13th, and once on 14th August 1998. It appears to have been available from the ward's stock.

9.6.2. Also, on 11th August 1998, Haloperidol at a dose of 1mg orally twice daily.

9.6.2.1. On the Administration Record these doses are recorded as being given once on 11th, twice on 12th, twice on 13th, and once on 14th August 1998.

9.6.2.2. This appears to have been a drug not stocked on the ward but obtained from the hospital pharmacy.

9.6.3. On 12th August 1998, Oramorph 10mgs in 5mls to be given orally in a dose of 2.5 mls four hourly [equivalent to 5mgs of oramorph].

9.6.3.1. Although this prescription was apparently not administered this drug appears to have been available from the Ward's stock. This drug 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].

9.6.4. Also, on 12th August 1998, Oramorph 10mgs in 5mls to be given orally once at night.

9.6.4.1. Although this prescription was apparently not administered this drug appears to have been available from the ward's stock. This drug 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].

9.7. On 18th August 1998, Dr Barton prescribed for Mrs Richards diamorphine at a dose range of 40-200mg and also haloperidol a dose range of 5-10 mgs.

9.7.1. Both drugs were to be administered subcutaneously in 24 hours.

9.8. On 18th, 19th, 20th, and 21st August 1998, Mrs Richards was given simultaneously and subcutaneously midazolam 20mgs [this had been prescribed on 11th August 1998 but was first administered on 18th August 1998], diamorphine 40mgs, and haloperidol 5mgs in 24 hours. These drugs are recorded as being administered at the same time of day on each of the four days they were given. They were administered at 1145, 1120, 1045, and 1155 for 18th, 19th, 20th, and 21st August 1998 respectively. All these drugs were administered at the times stated and were signed off by initials as being co-administered by the same person each day. Over the four days of 18th, 19th, 20th, and 21st August 1998, at least three nurses [who were or should have been registered by the General Nursing Council as being qualified because of the dangerous drugs used] were involved in administering these drugs.

9.9. 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].

9.10. On a separate nursing record Mrs Richards' medications were written up as all being given for 12th August 1998 and all given by a syringe driver on 18th and 21st August 1998.

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Death certification and cremation

9. The circumstances of Mrs Richards death have been recorded as:

9.1. 'Reported by Dr BARTON [sic]. Deceased had undergone surgery for a fractured neck of femur. Repaired. Death cert[ificate] issued. [paragraph] THOMAS [sic] [paragraph]

9.2. The cause death was accepted by the Coroner on 24th August 1998 as being due to:-

9.2.1. '1(a) Bronchopneumonia'.

9.2.2. The death was certified as such by Dr J A Barton and registered on 24th August 1998.

9.3. The body was cremated.

Review

10. 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. She was then transferred to the Gosport War Memorial hospital for rehabilitation.

10.1. After her arrival there on 11th August 1998 she was seen that day by Dr Barton who at the end of a short case note wrote 'I am happy for nursing staff to confirm death.' On this same day, in addition to prescribing Oramorph four hourly orally, Dr Barton prescribed large dose-ranges of diamorphine, hyoscine, and midazolam to be given subcutaneously in 24 hours.

10.2. On 12th August 1998, on the 'Regular Prescription' of the drug chart, Dr Barton wrote additional prescriptions for Oramorph 5mgs four hourly and 5 mgs at night. These two prescriptions have the letters 'PRN' written at their side within ink-framed boxes.

10.3. On 13th August 1998, Mrs Richards dislocated her artificial hip joint. There is no evidence that a doctor examined her after this incident until the following day. No arrangements were made for Mrs Richards to be transferred back to Haslar hospital for reassessment until after she was x-rayed at the Gosport War Memorial hospital at about lunchtime on 14th August 1998.

10.4. Despite her confused state, Mrs Richards was considered by medical staff at the Royal Hospital Haslar to be suitable for reduction of the dislocation. Three days later she was transferred back to the Gosport War Memorial hospital on a sheet and not a canvas

stretcher. She was very distressed when she reached Daedalus ward. Subsequently she was found to have a haematoma near to the site of her previous operation.

10.5. Despite the apparent insistence of Mrs Lack, who had visited Haslar hospital on the morning of 17th August 1998 and had the invitation to have her mother re-referred to Haslar hospital, there is no evidence that Dr Barton sought advice from Haslar hospital about re-referring Mrs Richards again. Instead, Dr Barton prescribed additional diamorphine and haloperidol at high and wide dose-ranges to be administered subcutaneously through a syringe driver. These were in addition to the prescription for subcutaneous administration of midazolam in a high dose-range. On the following day Dr Barton also added a prescription for the subcutaneous administration hyoscine.

10.6. There is no evidence showing who was responsible for selecting from the prescribed drug dose-range the actual dosage of the drugs used continually in the syringe driver until Mrs Richards died.

10.7. There is no evidence that a doctor or a nurse assessed Mrs Richards' pain relief from these medications.

10.7.1. There is, however, indisputable evidence that the drugs (diamorphine, midazolam, and hyoscine) were administered continuously subcutaneously until she died.

10.7.2. There is no evidence that the clinical effects of these drugs were being monitored and the their doses adjusted according to their clinical effects on Mrs Richards.

10.7.3. During this period when the syringe driver was being used to administer drugs, there is no evidence that Mrs Richards was given fluids in any appropriate manner or food.

10.8. When Mrs Richards had been first admitted to Daedalus ward on 11th August 1998 for remobilisation as arranged by the consultant geriatrician, Dr Reid, Dr Barton had written in the case records that 'I am happy for nursing staff to confirm death.'

10.9. After some four days of continuously being given the potent drugs described above, the nursing staff confirmed Mrs Richards' death.

Opinion

11. At the age of 91 years, and despite her confused mental state, Mrs Richards had been considered well enough for two operations on her right hip.

11.1. Following her second operation she was transferred back to Daedalus ward at Gosport War Memorial hospital on 17th August 1998. She appears to have been injured during the transfer, which was not conducted in the usual manner. As a result she was in severe pain.

11.2. 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.

11.3. She was instead continuously given, subcutaneously by syringe driver, high doses of potent and dangerous drugs from 18th August 1998 which were unmonitored as to the appropriateness of their effects on Mrs Richards' pain relief and general condition of well being until she died on 21st August 1998.

11.4. There is no evidence that either Dr Barton or the nursing staff or any other person or persons clinically responsible for Mrs Richards monitored the appropriateness of the administration of these drugs that Dr Barton had prescribed. There is evidence, however, that Dr Barton began these prescriptions from 11th August 1998 when she first saw Mrs Richards on Daedalus ward at Gosport War Memorial hospital. At this time Mrs Richards was pain-free. Moreover, she had been transferred to Daedalus ward following assessment by a consultant geriatrician who had stated her condition was appropriate enough for rehabilitation.

11.5. Dr Barton and the nursing staff involved in the administration of the drugs given to Mrs Richards by syringe driver had a duty of care towards Mrs Richards.

11.6. There has been breach of the duty of care by Dr Barton and the nursing staff involved in the administration of the drugs given to Mrs Richards by syringe driver.

11.7. No other event occurred to break the chain of causation and Mrs Richards' death was directly attributable to the administration of the large doses of drugs she continuously received by syringe driver from 18th August 1998 until her death on 21st August 1998.

11.8. There is no evidence that Mrs Richards' death was caused my pneumonia.

11.9. It is most probable if not certain that the cause of Mrs Richards' death was respiratory depression as a consequence of the large doses of drugs she continuously received by syringe driver from 18th August 1998 until her death on 21st August 1998 and or the effects of dehydration.

Conclusions

12. My conclusions are as follows:-

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12.1. I would support an allegation of assault occasioning actual bodily harm by person or persons at present unknown and who were involved in the transfer of Mrs Richards from the Royal Hospital, Haslar to Daedalus ward at the Gosport War Memorial Hospital on 17th August 1998.

12.2. I would also support an allegation of the criminal assault of Mrs Richards by Dr Barton and occasioned by Dr Barton's prescription of the drugs given by syringe driver.

12.3. I would also support allegations of the criminal assault of Mrs Richards by the nursing staff involved in the administration of the drugs given by syringe driver.

12.4. I would also support an allegation of the unlawful killing of Mrs Richards by the gross negligence of Dr Barton and occasioned by Dr Barton's prescription of the drugs given by syringe driver.

12.5. I would also support allegations of the unlawful killing of Mrs Richards by the gross negligence of the nursing staff involved in the administration of the drugs given to Mrs Richards by syringe driver.

12.6. I recommend that additional enquiries be instituted to determine if other patients at the Gosport War Memorial Hospital have been affected in a manner similar to that of Mrs Richards.

Research

13. Texts used for reference have included:

13.1. *Toxic psychiatry. Drugs and electroconvulsive therapy: the truth and the better alternatives.* Peter R Breggin. 1993. HarperCollins Publishers. London. pp 578.

13.1.1. Mrs Mackenzie has referred to this book in her statement. She also sent a copy to her mother's general practitioner, Dr Bassett. At that time, he was treating her mother who was a resident in the Glen Heathers Nursing Home.

13.2. *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.

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Special terms used [to be defined]

Diamorphine

Haloperidol

Hyoscine

Lactulose

Midazolam

Trazodone

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Ongoing issues

Was the patient unable to swallow?

Was there a need to increase or decrease the dosage of the drugs used? Who assessed this?

Drugs given subcutaneously are not more effective than drugs given orally.

The syringe driver (? Graseby) describe?

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The aims of palliative care remain constant and have been defined as:

'...active total care offered to a patient with a progressive disease and their family when it is recognised that the illness is no longer curable, in order to concentrate on the quality of life and the alleviation of distressing symptoms within a framework of a co-ordinated service. Palliative care neither hastens nor postpones death, it provides relief from pain and other distressing symptoms, integrates the psychological and spiritual aspects of care. In addition it offers a support system to help relatives and friends cope during the patients illness and in bereavement.'[1]

Principles of palliative care[2]

1. Affirms life and regards dying as a normal process

2. Neither hastens nor postpones death

3. Provides relief from pain and other distressing symptoms

4. Integrates psychological, social and spiritual aspects of care so that patients may come to terms with their own death as fully and as constructively as they can

5. Offers a support system to allow patients to live as actively and creatively as possible until death

6. Offers a support system to help families cope during a patient's illness and in bereavement

REFERENCES

1. World Health Organisation Regional Office for Europe: Palliative cancer care-Policy statement based on the recommendations of a WHO Consultation (1989) cited in: Standing Medical Advisory Committee and Standing Nursing and Midwifery Advisory Committee (1992) The principles and provisions of palliative care. Joint report of the Standing Medical Advisory Committee and Standing Nursing and Midwifery Advisory Committee, London.

2. Higginson I. Palliative and terminal care. In: Stevens A, Raftery J. *Health care needs assessment.* (Epidemiology based needs assessment reviews, second series.) Oxford: Radcliffe Medical Press, 1997.

Pain control in palliative care

Step-by-step approach.

1 Non-opiods (paracetamol)

2 Opiods (codeine) + step 1 drugs

3 Strong opiods (morphine, diamorphine) important to titrate the dose beginning with 2.5-5mgs four hourly. Be careful in those who are opiod naïve. When stabilised then use a modified release preparation (Oramorph SR, MST Continus). Oramorph SR is a tablet, MST Continus can be made up in suspension if tablet swallowing is not possible. Always make a rapid action opiod available for break through pain and at one sixth of the total daily opiod dose.

4 The oral route for drug administration is preferred. Opiods are easily absorbed and not more effective if given parenterally.

Regulations for controlled drugs

There are regulations for the prescription, storage, recording, and destruction of controlled drugs.

Use of unlicensed drugs

Responsibility for use is the clinician's or the pharmacist's rather than the manufacturer.

Additional issues

Did the act or omission of the 'ambulance transport staff' materially contribute to the death of Mrs Richards?

Did the act or omission of Dr B materially contribute to the death of Mrs Richards?

Did the act or omission of the nursing staff materially contribute to the death of Mrs Richards?

Did the act or omission of the pharmacist or pharmacy department materially contribute to the death of Mrs Richards?

Did the act or omission of the hospital materially contribute to the death of Mrs Richards?

Did the act or omission of any other person(s) materially contribute to the death of Mrs Richards?

Did Dr B hasten Mrs Richards' death intentionally?

If intentionally, was this the foreseeable consequence of symptom relief – or was it clinical negligence – or the aggressive practice of palliative care?

If the ~~the~~ aggressive practice of palliative care, was such aggressive palliative care required and/ or appropriate – or could symptom relief have been achieved by other more appropriate means?

Was the death of Mrs Richards a foreseeable or unforeseeable consequence of her treatment?

Why was midazolam prescribed on 11th August 1998 and not given?
Midazolam is not licensed for subcutaneous use. Was its use in this way common practice on the ward and/or in that hospital? What was the pharmacist's responsibility in overseeing drug usage? What is the vicarious responsibility of the hospital in this matter in terms of its clinical governance? [Clinical governance is 'clinical practice delivered to accepted standards that are routinely monitored through clinical audit and clinical risk management and all supported by procedures for adverse outcome reports and their evaluation.]

How many other patients have died under similar circumstances while under the care of Dr B or other doctors at the hospital?

How many cremations have taken place? How many burials have there been and would exhumation(s) be appropriate?

What was the role of the Coroner and/or the Registrar of Births, Marriages, and Deaths in this matter?

Comment

At present I find it difficult to conceive of an innocent explanation for the prescription of the drugs for and the circumstances of their administration to Mrs Richards following her admission to Gosport War Memorial hospital.

What is clinical negligence?

To succeed in a claim of clinical negligence against a doctor, the patient (who becomes a claimant) must prove, on the balance of probabilities, that:

- the doctor owed a duty of care
- there was a breach of that duty
- harm followed as a result (causation is established).

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The writer's declaration

I, BRIAN LIVESLEY, DECLARE THAT:

1. I understand that my duty in providing written reports and giving evidence is to help the Court, and that this duty overrides any obligation to the party who has engaged me. I confirm that I have complied with that duty.

2. I believe that the facts I have stated in this report are true and that the opinions I have expressed are correct.

3. I have endeavoured to include in my report those matters, which I have knowledge of or of which I have been made aware, that might adversely affect the validity of my opinion.

4. I have indicated the sources of all information I have used.

5. I have not without forming an independent view included or excluded anything which has been suggested to me by others (in particular my instructing lawyers).

6. I will notify those instructing me immediately and confirm in writing if for any reason my existing report requires any correction or qualification.

7. I understand that:

   a) my report, subject to any corrections before swearing as to its correctness, will form the evidence to be given under oath;

   b) I may be cross-examined on my report by a cross-examiner assisted by an expert; and,

   c) I am likely to be the subject of adverse criticism by the Judge if the Court concludes that I have not taken reasonable care in trying to meet the standards set out above.

8. **I confirm that I have not entered into any arrangement where the amount or payment of my fees is in any way dependent on the outcome of the case.**

Brian Livesley 28 October 1999