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For the attention of John Baker

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Our Ref: 558203/000001/JCW/RICHARD/S2D

Your Ref:

19 March 2013

Dear Sirs

Mrs Gladys Mabel Richards (Deceased) – Inquest
Exceptional Funding

You may recall this inquest which has the benefit of funding from a Ministry of Justice Grant to provide representation at the hearing.

Previously on 6 March 2012 we also approached you asking for permission to incur the expense of instructing an independent medical expert. Please note that since that time the Coroner has permitted that report to be adduced in the inquest evidence. It is now planned that the expert will attend at the hearing.

The hearing has been re-listed before HM Coroner for Portsmouth and is due to take place on 9 April 2013 for two weeks, i.e., 9 - 19 April 2013 (inclusive). The medical expert, Professor Ferner, is due to attend the hearing in the first week of the hearing.

Our reason for writing at this time is that there were a number of additional elements to the work since public funding was granted. Also, we would like to request confirmation in respect of the expert's fees. We enclose a copy of Counsel's advice and also the estimated costs for the expert.

The additional work has included three pre-inquest reviews, all of which were attended by Counsel because of their importance, on the following dates : -

- 12.05.11;
- 31.10.12; and
- 12.12.12.

With £500.00 for the refresher fee for Counsel, the refreshers alone for the inquest will be £4,500.00. The documentation is extensive. With a brief fee of £3,000.00, provision for a pre-inquest conference of £2,000 and then adding the fee for the expert of £2,000.00 gives us a total of £11,500.00 before any of our own costs for attending the inquest hearing are added. We will have one person attending for each day throughout the hearing.

We point out that there is wider public interest in this hearing and we have already had to incur £40,000.00 of time in managing this case.

In these circumstances, we would like to ask that the grant is revised, so as to provide for an overall costs limitation of £25,000.00 so that we can conduct the inquest hearing.

Please can you review this urgently and we look forward to hearing from you. Should you have any questions concerning this letter or require further details, please ask to speak to John White.

Yours faithfu

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ESTIMATED COSTS FOR MEDICAL EXPERT

Re Gladys Richards (dec) - expert's costs

Further to yesterday I have set out the estimated costs for the expert as follows : -

His hourly rate is £100 per hour.

(i) Preparation of a report:

10 hours work x £100 ph = £1,000

(ii) Conference with Counsel in London lasting 2 - 3 hours:

Travelling and waiting time from Sheffield would be around 6 hours at £50 ph = £300

Attendance for 2.5 hours x £100 ph = £250

Travel costs = £180

Total for conference = £730

(iii) Attending inquest for one day in Portsmouth

One day in Portsmouth would require the expert coming down the night before

Fee for one day in Court = £500

Travel cost = £250

Cost of a hotel (we estimated) = £150

Total for Court attendance = £900

Total funding requested (ex-VAT) = £2,630.00

Please can you consider this request and if the MOJ grant can be amended to include this cost.

IN HM CORONER'S COURT PORTSMOUTH

RE: GLADYS MABEL RICHARDS (DECEASED)

ADVICE ON APPLICATION TO LEGAL SERVICES COMMISSION
FOR FUNDING FOR EXPERT REPORT

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1. I have been asked to advise on the possibility of making an application to the Legal Services Commission (the 'LSC') for funding for an expert report, and the attendance of the expert, at the inquest into the death of Gladys Mabel Richards. Those Instructing represent Mrs Richards' daughter, Mrs Gillian MacKenzie.

2. Mrs Richards' death was one of a number of deaths which occurred at Gosport War Memorial Hospital ('GMWH') in the 1990s. These deaths have led to inter alia, 4 criminal investigations, a report by the Commission for Health Improvement and a finding by the General Medical Council ('GMC') against the doctor in charge, Dr Jane Barton. The Assistant Coroner for Portsmouth considered 10 of these deaths at a previous inquest in 2009.

3. The present inquest into the death of Mrs Richards is likely to be the final hearing which deals with these matters. The inquest was opened in March 2009 and immediately adjourned. The inquest is not subject to the provisions of the Human Rights Act 1998 (the 'HRA') as Mrs Richards' death took place before the HRA came into force.

4. The Coroner has stated that he will be using 1 expert report in the inquest. This is a report produced by Professor Black dated 2 March 2011. In summary, it is my advice that if a Prof Black's report is the only expert evidence in this case it will be impossible to put Mrs Mackenzie's case in any meaningful way at the inquest. It is for this reason that another expert report is required. Any such expert would of course be required to attend the inquest and meet Counsel at a date before the hearing.

Facts

5. Mrs Richards was born on [Code A] and died on 21 August 1998 age 91. She has 2 daughters, Mrs Mackenzie and her younger sister Mrs Lesley Lack.

6. Mrs Richards became a resident at the Glen Heathers Nursing Home on 5 August 1994. She was 87 and although disorientated and confused she was able to wash and dress herself, go up and down stairs and walk well. Her condition appears to have deteriorated and at the beginning of 1998 she became increasingly forgetful and less able physically. She was inclined to wander and had an approximately 6 month history of falls. Her hearing aid and spectacles became lost, compounding the confusion.

7. On 29 July 1998 Mrs Richards sustained a fracture of the neck of right femur and was transferred to the Royal Hospital Haslar, Gosport. On 30 July 1998 she had an artificial hip joint inserted in her right hip. On 5 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. However, notwithstanding her dementia, she should be given the opportunity to try to re-mobilise. Therefore he arranged for to be transported to GWMH.

8. She was transferred to Daedalus ward at GWMH on 11 August 1998. Mrs Richards was described as not being any pain. She was fully weight-bearing on leaving Haslar and she was walking with the aid of 2 nurses and a Zimmer frame.

9. Dr Barton has written in the medical case records on 11 August 1998:

> 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 were voiced Usually continent needs help with ADL [activities of daily living] ... I am happy for nursing staff to confirm death.

10. Mrs Richards is recorded as having been found on the floor after an apparent fall at approximately 1300 hours on 13 August 1998. Dr Brigg was contacted and advised an x-ray in the morning. Dr Barton recorded on 14 August 1998 that Mrs Richards fell out of her chair the previous night and asked 'Is this lady well enough for another surgical procedure?' She also noted that Mrs Richards was very sensitive to oramorph. Notwithstanding her concerns, she arranged for Mrs Richards to be transferred back to Haslar.

11. Mrs Richards was transferred back to Haslar on 14 August 1998 having been given 10 mg of Oramorph. The x-ray at the Royal Hospital Haslar confirmed that the artificial hip had dislocated. Intravenous sedation allowed the dislocation to be corrected by traction. She was

admitted to the Royal Hospital for 48 hours observation. Apart from 2 tablets of Co-codamol on 15 August 1998 she did not need to be given any pain relief following the reduction of hip dislocation.

12. On 17 August 1998 she was considered fit enough for discharge. She was to remain in a straight knee splint for 4 weeks. No follow-up was deemed necessary unless complications arose. Therefore she was returned to Daedalus Ward at GWMH. The discharge summary mentions the use of haloperidol, lactulose, co-codamol and oramorph for pain. Although the oramorph was never given to Mrs Richards at Haslar. There is no evidence that Mrs Richards, although in pain, had any specific life-threatening or terminal illness that was not amenable to treatment and from which she could not be expected to recover.

13. After readmission to GWMH that day, Dr Barton writes in the notes that Mrs Richards is to continue haloperidol and only to be given oramorph if in severe pain. There is no record of any assessment of Mrs Richards' mental or physical state on transfer except a statement that she 'now appears peaceful'. However the nursing cardex of the same day states that the patient appears distressed and in pain. Due to the pain a further x-ray is ordered and no dislocation is found.

14. Dr Barton notes on 18 August 1998 that the patient was still in great pain, that nursing was a problem. Notwithstanding her knowledge of Mrs Richards' sensitivity to oral morphine and midazolam, she suggests subcutaneous diamorphine, haloperidol and midazolam. Neither midazolam nor haloperidol is licensed for subcutaneous administration. Although such administration can take place in end-of-life care for cancer, it is noted that Mrs Richards was not receiving any treatment for cancer.

15. The nursing cardex records the decision to control the pain by syringe driver. She then receives diamorphine 40 mg daily in a syringe driver, with haloperidol 5 mg and 20 mg Midazolam until her death. During this period there is no evidence that Mrs Richards was given life-sustaining fluids or food.

16. Mrs Richards died on 21 August 1998 on Daedalus ward at GWMH. The death was certified as such by Dr Barton and registered on 24 August 1998. The cause of death was stated to be bronchopneumonia. A post mortem was not obtained. The death certificate makes no mention

of Mrs Richards' fractured neck of femur or her dementia. Mrs Richards was subsequently cremated.

17. At least 3 expert reports have been prepared, and disclosed, into the death of Mrs Richards. It is proposed to deal with each of these in chronological order.

Report of Professor Livesley - 10 July 2001

18. In 2001 Hampshire Constabulary commissioned Prof Brian Livesley to provide 'an independent view about treatment given to Mrs Gladys Richards and the factor(s) associated with her death'.

19. Prof Livesley concluded that there was evidence to show that Mrs Richards was capable of receiving oral medication for the relief of pain she was experiencing on 17 August 1998. She was known by Dr Barton to be sensitive to oramorph and had prolonged sedated response to intravenous midazolam. Notwithstanding this, Dr Barton prescribed continuous subcutaneous administration of diamorphine, haloperidol and midazolam from 19 August 1998 until Mrs Richards' death on 21 August 1998. There is no evidence of Mrs Richards receiving any foods or fluids to sustain her from 18-21 August 1998. (Section 8, page 17)

20. It is Prof Livesley's conclusion that this continuous subcutaneous administration of prescribed drugs led to Mrs Richards becoming unconscious and dying on 21 August 1998. He goes on to state that:

> 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 drugs continuously received by syringe driver from 18 August 1998 until her death on 21 August 1998. (Paragraph 8.10)
>
> 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. (Paragraph 8.11)

21. His report lists clear failings on the part of Dr Barton which began the chain of causation leading to Mrs Richards' death. His report was used by the GMC's Fitness to Practise Panel in its deliberations into Dr Barton's fitness to practice between 8 June-21 August 2009.

Reports of Professor Ford - 12 December 2001 & 21 April 2009

22. Prof Ford was asked by the Hampshire Constabulary (in 2001) to examine the clinical notes of 5 patients including Mrs Richards. He was asked to apply his professional judgements to, inter alia; the accuracy of diagnosis and prognosis including risk assessments, and evaluation of drugs prescribed and the administration regimes, the quality and sufficiency of the medical records and the appropriateness and justification of the decisions that were made. He was also asked to consider the duty of care issues and highlight any failures. He was further instructed (in 2009) to report on the care of Mrs Richards to assist the GMC Fitness to Practice Panel.

23. Having considered the history of Mrs Richards' care and prescription of drugs in her case Prof Ford came to conclusions not favourable to Dr Barton. He makes clear that:

> 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. (Paragraph 2.26)

24. Under the heading 'Appropriateness and justification of the decisions that were made' Prof Ford states as follows:

> There are a number of decisions made in the case 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 opiates or other analgesic drugs was inappropriate. The decision to prescribe diamorphine, haloperidol and midazolam by subcutaneous infusion was, in my opinion, highly inappropriate. (Paragraph 2.29)

25. When considering 'Duty of care issues' Prof Ford concludes:

> 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 Richards' hydration and nutritional needs was also in my opinion probably not met. (Paragraph 2.31)

26. In his supplementary report of 21 April 2009 for the GMC he concludes:

> Dr Barton in her care of Patient E [Mrs Richards] failed to meet the requirements of good medical practice:
> - to provide adequate assessment of a patient's condition based on the history and clinical findings and including where necessary an appropriate examination;

- to keep clear, accurate contemporaneous patient records which report the relevant clinical findings, the decisions made, information given to patients and any drugs or other treatments prescribed;
- to prescribe only the treatment, drugs or appliances that serve patients' needs.

27. Those Instructing will need no further advice on the significance of these conclusions, consistent with Prof Livesley, that there were clear negligent failings in the treatment of Mrs Richards.

Report of Professor Black - 2 March 2011

28. Prof Black was instructed by the Coroner to complete a review of the medical evidence in this case. He notes significant failings in Dr Barton's care of Mrs Richards. He states that the decision to prescribe oral morphine upon Mrs Richards' initial admission to GWMH was 'highly suboptimal prescribing' (paragraph 4.6). He then goes on to state in relation to the later prescription of oramorph that 'to prescribe a controlled drug without a clinical indication must be considered negligent in my view' (paragraph 4.8).

29. In his conclusions he states that there were significant failings in the medical care provided to Mrs Richards. However he does not make clear that Dr Barton's actions contributed the death of Mrs Richards. He simply says:

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

30. This conclusion is clearly a much weaker conclusion than that reached by the 2 experts who considered the case in 2001. There can be no doubt that the significance of these differences will have a huge impact on the possible verdict the Coroner can come to and the likelihood of what verdict he will reach.

Potential verdict of 'unlawful killing'

31. Mrs Mackenzie is certain that the evidence supports a finding of 'unlawful killing'. There is strong support for this proposition in the medical records and statements of those concerned in Mrs Richards' care. It is supported by the conclusions in the reports of Prof Livesley & Prof Ford. However the Coroner has indicated, at the pre-inquest hearing, that he does not consider

there to be sufficient evidence to support such a verdict. This is in part because there is only very mild support for the proposition in Prof Black's report.

32. As Those Instructing will be aware the burden and standard of proof for reaching such a conclusion are very high. It must be shown beyond a reasonable doubt that gross negligence manslaughter has taken place. In short, it will be impossible to reach this conclusion using the uncontradicted report of Prof Black. Although it will be possible to challenge some of his conclusions through cross-examination, this will not be effective without expert opinion along the lines of that provided by Prof Livesey or Prof Ford.

33. Those Instructing have contacted the Coroner and asked him to call the professors who have previously prepared reports on Mrs Richards' death and to place those reports within the inquest documentation. Having written to him on 1 December 2011 commending this approach as clear and cost-effective it was subsequently rejected by the Coroner.

34. The Coroner has made clear that the report of Prof Black is sufficient for the scope of his enquiries and he does not wish to fund preparation of another expert report. However were Mrs Mackenzie's representatives able to fund an independent expert to consider the case, such an expert's evidence would be considered.

35. This leaves Mrs Mackenzie in the unfortunate position that the only way to advance her case successfully at the inquest is by obtaining funding for the attendance of, and preparation of a report by, a further expert.

36. Those Instructing have been in contact with Professor Forrest and I am in agreement that he would be a perfect candidate for this work. I would advise that he be instructed to review the available evidence with the same terms of reference as given to Professor Ford by the Hampshire Constabulary in 2001. This can be found at the front of his report of 12 December 2001.

Conclusion

37. The death of Gladys Richards raises complex issues of fact and law. At least 3 experts have considered the death and found substantial irregularities in her treatment by Dr Barton. The 2 experts that were relied upon at the GMC's Fitness to Practise Panel are supportive of Mrs

Mackenzie's version of events. That is to say, their conclusions support a possible verdict of unlawful killing. The Coroner has instead decided to rely upon a new report produced by Prof Black. While this does find significant failings in Mrs Richards' care, it is not supportive of a possible verdict of unlawful killing. Nor is the report supportive of the proposition that the inappropriate prescription of drug treatments in Mrs Richards' case made any significant difference which hastened her death. Without a further expert report it will be impossible to put Mrs Mackenzie's carefully considered case that her mother's death is the result of gross negligence manslaughter.

38. It is therefore essential that a suitable expert, such as Prof Forrest, produce an initial report into this case. He will also need to attend a pre-inquest conference with Counsel and attend 1 day of the inquest hearing itself. Without the instruction of such an expert the family are unlikely to get anything positive from the inquest hearing.

39. For these reasons it is submitted that the LSC should provide funding for an expert in this case.

JAMES MEHIGAN
Tooks Chambers

14 February 2012