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SUMMARY OF CONCLUSIONS

Sheila Gregory a 91 year old lady with a number of serious chronic diseases suffers a fall and fractured neck of femur in August 1999. She is admitted to the Haslar Hospital and making little rehabilitation progress, with a very poor prognosis she is transferred to the Gosport War Memorial Hospital.

There is some weakness in the documentation of her condition in particular on her admission to the Gosport War Memorial Hospital and on the 18th November when her definitive final clinical deterioration is documented. If clinical examinations were undertaken they have not been recorded. General Medical Practice (GMC2001) states that "good clinical care must include adequate assessment of the patient's condition, based on the history and symptoms and if necessary an appropriate examination"..... "in providing care you must clear, accurate, legible and contemporaneous patient records which must report the relevant clinical findings, the decisions made, the information given to patient's and any drugs or other treatment prescribed". The lack of clinical examination both on admission and more important Mrs Gregory care deteriorated represents poor clinical practice to the standards set by the General Medical Council.

Despite the above I am satisfied that Mrs Gregory's death was of natural causes and that her overall clinical management in Gosport was just adequate.

1. INSTRUCTIONS

To examine the medical records and comment upon the standard of care afforded to the patient in the days leading up to her death against the acceptable standard of the day. Where appropriate, if the care is felt to be sub-optimal, comment upon the extent to which it may or may not disclose criminally culpable actions on the part of individuals or groups.

2. ISSUES

2.1. Was the standard of care afforded to this patient in the days leading up to her death in keeping with the acceptable standard of the day?

2.2. If the care is found to be suboptimal what treatment should normally have been proffered in this case?

2.3. If the care is found to be suboptimal to what extent may it disclose criminally culpable actions on the part of individuals or groups?

3. CURRICULUM VITAE

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Name	Professor David Andrew Black
Address	Code A
Telephone	Code A **E-mail:** Code A
DOB	
Place	Windsor, England.
GMC	Full registration. No: Code A
Defence Union	Medical Defence Union. No: Code A

EDUCATION

Leighton Park School, Reading, Berks.	1969-1973
St John's College, Cambridge University.	1974-1977
St Thomas' Hospital, London SE1	1977-1980

DEGREES AND QUALIFICATIONS

BA, Cambridge University	1977
(Upper Second in Medical Sciences)	
MB BChir, Cambridge University	1980
MA, Cambridge University	1981
MRCP (UK)	1983
Accreditation in General (internal) Medicine and Geriatric Medicine	1989
FRCP	1994
MBA (Distinction) University of Hull.	1997
Certificate in Teaching	2001
NHS/INSEAD Clinical strategists program	2003

SPECIALIST SOCIETIES

British Geriatrics Society

British Society of Gastroenterology

British Association of Medical Managers

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PRESENT POST

Dean Director of Postgraduate Medical and Dental Education	
Kent, Surrey and Sussex Deanery.	2004-present
Honorary Chair in Medical Education Brighton	
and Sussex Medical School	2005
Consultant Physician (Geriatric Medicine)	1987-present
Queen Mary's Hospital, Sidcup, Kent.	
Associate member General Medical Council	2002-present

PREVIOUS POSTS

Associate Dean.	
London Deanery.	2004
Medical Director (part time)	1997-2003
Queen Mary's Hospital	
Operations Manager (part time)	1996-1997
Queen Mary's Hospital, Sidcup, Kent	
Senior Registrar in General and Geriatric Medicine	
Guy's Hospital London and St Helen's Hospital	
Hastings.	1985-1987
Registrar in General Medicine and Gastroenterology	
St Thomas' Hospital, London.	1984-1985
Registrar in General Medicine	
Medway Hospital, Gillingham, Kent	1983-1984
SHO rotation in General Medicine	
Kent & Canterbury Hospital, Canterbury	1982-1983
SHO in General Medicine	
Kent & Sussex Hospital, Tunbridge Wells	1981-1982
House Physician, St Thomas' Hospital	1981
House Surgeon, St Mary's Portsmouth	1980

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Secondary care as part of the whole system. Laing & Buisson conference on intermediate care. April 2001
The impact of the NSF on everyday Clinical Care. Conference on Clinical governance in elderly care . RCP May 2001
The Geriatricians view of the NSF. BGS Autumn Meeting 2001

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The Organisation of Stroke Care. Physicians and managers working together to develop services. Professional training and clinical governance in geriatric medicine. All at Argentinean Gerontological Society 50th Anniversary meeting. Nov 2001

The future of Geriatric Medicine in the UK. Workshop: American Geriatrics Society May 2002

Liberating Front Line Leaders. Workshop: BAMM Annual Meeting June 2002

Revalidation - the State of Play. A Survival Guide for Physicians. Mainz July 2002

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Developing Consultant Careers. Workshop: BAMM Medical Directors Meeting. Nov 2002

Lang and Buisson. Update on Intermediate Care Dec 2002

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Designing care for older peoples. Emergency services conference. London July 2004.

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Geriatricians and Acute General Medicine. BGS Autumn Meeting . Harrogate Oct 2004

4. DOCUMENTATION

This Report is based on the following documents:

[1] Full paper set of medical records of Sheila Gregory (BJC/21)

[2] Operation Rochester Briefing Document Criminal Investigation Summary.

[3] Hampshire Constabulary Operation Rochester Guidance for Medical Experts.

[4] Commission for Health Improvement Investigation Report on Portsmouth Health Care NHS Trust at Gosport War Memorial Hospital (July 2002).

[5] Palliative Care Handbook Guidelines on Clinical Management, Third Edition, Salisbury Palliative Care Services (1995); Also referred to as the 'Wessex Protocols.'

5 CHRONOLOGY/CASE ABSTRACT. (The numbers in brackets refer to the page of evidence, the numbers with 'H' in front are the Haslar notes).

5.1. Sheila Gregory a 91 year-old lady in 1999 was admitted as an emergency on 15th August 1998 to Haslar Hospital (H32).

5.2. She had a number of chronic conditions including a partial Thyroidectomy and Hypertension. In 1990 (H198) she was admitted with acute on chronic episode of obstructive airways disease. In 1991 (H205) an episode of abdominal pain and vomiting that was thought possible was pancreatitis. During this admission she received 6 doses on Omnopon each of 20 mgs with no ill effect (H363). (Omnopon is Papaveretum, 15.4mg is the equivalent of 10mg of Morphine). In 1995 she attends the geriatric day hospital under the care of a consultant geriatrician with a number of problems, including headaches (13), slow atrial fibrillation (33), left ventricular failure and mitral regurgitation (37) confirmed by an echo cardiogram (79). She has an episode of diplopia (39) and is noted to have marked bruising

(65).

5.3. She is thought to be depressed and is referred to a Dr Banks a psycho-geriatrician, who does not think she is significantly depressed but although she scores 10/10 on the mental test score, he does suspect possible early dementia. At that time she is on Frusemide, Thyroxine, Aspirin, regular Co-Proxamol and inhalers.

5.4. In December 1998 she is admitted severely ill to Haslar Hospital with chronic airways disease and left ventricular failure (H40). She is in severe respiratory failure with a measured partial pressure of carbon dioxide (pCO_2) of 12.6 (H49). However, she does recover and on this admission is declined Social Services intervention. In February 1999 (H31) she is reviewed in outpatients for episodic breathlessness. A chest x-ray in December 1998 (H8) confirms that she had heart failure.

5.5. On 15th August 199 she is admitted with a fractured proximal right femur (H32) and has a dynamic hip screw performed on 16th August (H32). She seems to make a relatively uneventful recovery medically, although the occupational health notes on 20th August show that she is needing two to do most things and comments that she is not overly motivated (H64). On 27th August her right leg is noted to be swollen and is started on Erythromycin (H84/85). On 1st September it is still swollen (H86).

5.6. In the meantime she has been referred to the geriatric team and is seen on 24th August (11). Dr Tandy documents that she had a fractured neck of femur, that she has had acute on chronic confusion since the operation and that she had an episode of diarrhoea. He also writes in the Haslar notes after saying that he will transfer her to Gosport, "will get home?" (H83).

5.7. She is transferred on 3rd September 1999 to Gosport and the letter from Haslar (9,10) states that she is using a Zimmer frame with help, has an indwelling catheter and is doubly incontinent. It also documents that she has had previous asthma, heart failure and is allergic to Penicillin. It states that at times she is very confused.

5.8. The notes on transfer to Dryaed Ward 966) (Dr Barton) record she had a fractured neck of femur and a past medical history of

hypothyroidism, asthma and cardiac failure. Needs help with ADL. She is incontinent and transfers for two with a Barthel of 3-4. The plan is to get to know her, gentle rehabilitation and she may need a nursing home. The record asks the nurses to make her comfortable and states "I am happy for the nursing staff to confirm death".

5.9. On 6th September (67) she is seen by a different doctor after she had been noted to have a left-sided facial droop which has resolved. An examination is recorded in the notes and it also notes that she has pain tenderness in her right wrist. ("snuffbox"). She is started on Aspirin for her atrial fibrillation and x-rays are arranged. The x-ray showed no bony injury (127). At this stage 9195) her Barthel is 2 (very heavily dependent) with a Waterlow score of 35 (191) identifying that she at very high risk of pressure sores.

5.10. She is then reviewed regularly on the ward with comment most weeks (67-69). In summary they document her very poor appetite, agitation and variable confusion with a lack of significant improvement in mobility. She remains catheterised and has faecal incontinence. Blood tests taken during this time, including a full blood count, liver function testand thyroid function test are all unremarkable (101,111,99), her weight on 22nd October is 45.3 kgs (226).

5.11. The lack of progress in rehabilitation and continued dependency, continues until the 1st November 1999 (69) when an episode of vomiting is noted. On 11th November, her Barthel is still very dependent at 6 (193).

5.12. On 15th November (69) she is noted to be less well, it is thought possible that she has a chest infection and is having nausea. An examination is undertaken and recorded in the notes but no firm diagnosis is recorded. But there appears to have been some sort of change in her status. However, on the 18th November (70) there is marked deterioration in her general condition. This is also noted in the nursing cardex (239), which states she is quite distressed and breathless. There is no medical examination recorded, however, it was decided to start oral opiates in a small dose and to"make comfortable". Dr Barton who saw her on this day records that she will speak to the granddaughter and again states that she was happy for nursing staff to certify death. She does suggest that there might have been a further stroke, but no examination is recorded.

5.13. On 19th November, nursing cardex reports her as poorly but stable. (239)
On 22nd November a further decline is noted and that she is comfortable, an examination is undertaken and recorded and notes that she is breathless, chest is clear and she has uncontrolled atrial fibrillation. The decision to continue the Diamorphine is recorded, she dies 17.20 on 22nd November, and death is verified by Staff Nurse Shaw and Staff Nurse Hamlyn (70).

5.14. There are three main drug charts in the notes for her stay in Gosport. The first is from the 3rd September to 6th October (154-166). This records regular Thyroxine, Iron Lactulose, Senna, Atrovent Becloforte, Paracetamol, Aspirin, Fluoxetine and nebulizers.

On the as required part there is Co-dydramol, Prochlorperazine, Oramorph 10mgs in 5 mls, 2.5 – 5 mls prn (never given) also Diamorphine, Hyoscine, Midazolam, all of which are never given and Thioridazine which she receives on a regular basis together with Zopiclone at night.

5.15. The next drug chart goes from 7th October – 17th November. Regular medication includes Thyroxine, Fluoxetine, Aspirin, Paracetamol, Senna, Lactulose, Thioridazine and Temazepam. She receives 3 days of antibiotics from 1st November – 3rd November.

On the as required part Oramorphine, 10mgs in 5mls 2.5 -5mls orally four hourly prn is written up and one dose is given on 11th November. Metoclopromide and Gaviscon Loperamide are also written up.

5.16. The final drug chart goes from the 18th November up unto her death. On the regular side Oramorphine 10 mgs in 5mls is written up and 2.5mls (i.e.5mgs) is given 6 hourly on 18th and 19th November and on the morning of 20th November (186). Thyroxine, Fluoxetine continue to be given regularly up until 21st November.

Diamorphine 20 – 80 mgs subcutaneously in 24 hours, together with Hyoscine, Midazolam and Cyclizine are all written up on the as required part of the drug chart on 18th November. Diamorphine 20 mgs in 24 hours with 50 mgs of Cyclizine is given in an infusion pump. The first one starting on 20th November and the second on 21st November.

6. TECHNICAL BACKGROUND / EXAMINATION OF THE FACTS IN ISSUE

6.1. This section will consider whether there were any actions so serious that they might amount to gross negligence or any unlawful acts, or deliberate unlawful killing in the care of Sheila Gregory. Also whether there were any actions or omissions by the medical team, nursing staff or attendant GP's that contributed to the demise of Sheila Gregory, in particular, whether beyond reasonable doubt, the actions or omissions more than minimally, negligibly or trivially contributed to death.

6.2. Mrs Gregory had a number of chronic diseases prior to her terminal admission following a fractured neck of femur. She had severe lung disease documented to going back to at least 1990, and in my view was extremely lucky to survive the admission in December 1998 at the age of 90 years. She also had documented heart failure, atrial fibrillation and heart cardiac valvular disease going back to at least 1995. It seems likely that she had cerebral vascular disease following the episode of diplopia in 1995 and the confusion that was subsequently documented is probably evidence of mild to moderate multiple infarct disease.

6.3. As is all too common, a very frail elderly lady has a fall and she suffered a fractured neck of femur. She is admitted to the Haslar Hospital for operative repair. There is always a very significant mortality and morbidity after fractured neck of femurs in old people, particularly in those who have had previous cardiac and other chronic diseases.

6.4. In the post operative period in Haslar, she remains doubly incontinent of both urine and faeces and has considerable confusion, especially at night. She makes very little rehabilitation progress. All of these are very poor prognostic signs at the age of 91.

6.5. She is subsequently assessed by the geriatric team and appropriately transferred to Gosport Hospital. The comment in the notes in Haslar, "will get home?" (H83) suggest that a consultant view was that even at this early stage, significant improvement was very unlikely. I would agree with that assessment.

6.6. When she is transferred to the Gosport War Memorial Hospital she is seen by Dr Barton who fails to record a clinical examination apart from some short statements about her past medical history and her functional history. However, Mrs Gregory appears to have been in a relatively stable clinical condition and no harm

seems to befall her as a result of this failure to examine her.

6.7. However, she is examined three days later by a different doctor when she had been noted to have a left sided facial droop and it seems quite likely that she had a further small stroke at this time as part of her multiple infarct disease.

6.8. Essentially she makes no improvement in rehabilitation during her two months in Gosport War Memorial. She remains extremely dependent, eating very little and reliant on very considerable nursing input. There is ongoing discussion about the possibility of a long term nursing home placement.

6.9. On 15th November she is noted to be quite unwell, the diagnosis was not entirely clear and I wonder whether something was actually starting on 1st November when there was an episode of vomiting. The patient is examined and that examination is recorded in the notes. However, by 18th November, she has very rapidly deteriorated and Dr Barton makes a record in the notes that because of her deterioration in general condition, oral opiates should be started in a small dose. Based on the nursing assessment of her distress and breathlessness, this was an appropriate response to someone who has an extremely poor prognosis, multiple chronic illnesses and is making no significant progress after 3 months in hospital. A symptomatic response to this lady's problems are a reasonable clinical decision.

6.10. She receives 5 mgs 6 hourly of Oramorphine on the 18th and 19th December, which I believe to be an appropriate dosage and therapeutic regime. No improvement is made and she starts on Diamorphine pump at 20 mgs on 20th November. It would appear that the decision to start this was a nursing one as no specific medical note is made on that day, however I believe this to have been a reasonable decision for a patient who is dying.

6.11. Diamorphine is specifically prescribed for pain and is commonly used for pain cardiac disease . However, it is also widely used for the distress and agitation that may be associated with terminal illness. Diamorphine can be mixed with Cyclizine (to prevent vomiting) in the same syringe driver. Diamorphine subcutaneously after Oramorphine is usually given a maximum ratio of 1 to 2 (for example up to 10 mgs of Diamorphine for 20 mgs of Oramorphine). On this occasion Sheila Gregory had been receiving 20 mgs of Oramorphine a day on 18th and 19th where an absolute minimum dose of Diamorphine would have been 10 mgs in the syringe driver over the first 24 hours. However the

increased to 20 mgs over 24 hours after 2 days of 20 mgs of Oramorphine would be within the range of acceptable clinical practice.

6.12. Seen on the 22nd, she is now very ill with a rapid pulse, a rapid respiratory rate with a clear sounding chest. This suggests to me that the agonal event may well have been a pulmonary embolus. However, this would not be surprising after a long period of poor mobilisation, following a fractured neck of femur.

6.13. A remaining concern regarding the clinical management is the anticipatory prescribing of strong opioid analgesia on both the first and second drug charts written between 3rd September and 17th November. Except where this would be useful as part on normal clinical management (for example after a heart attack), there appears to be no clinical justification for this prescribing pattern. However, although this may represent poor clinical practice, no harm came to Mrs Gregory as a result of it.

7. OPINION

7.1. Sheila Gregory a 91 year old lady with a number of serious chronic diseases suffers a fall and fractured neck of femur in August 1999. She is admitted to the Haslar Hospital and making little rehabilitation progress and with a very poor prognosis, she is transferred to the Gosport War Memorial Hospital.

7.2. There is some weakness in the documentation of her condition in particular on her admission to the Gosport War Memorial Hospital and on the 18th November when her definitive final clinical deterioration is documented. If clinical examinations were undertaken they have not been recorded. General Medical Practice (GMC2001) states that "good clinical care must include adequate assessment of the patient's condition, based on the history and symptoms and if necessary an appropriate examination"..... "in providing care you must clear, accurate, legible and contemporaneous patient records which must report the relevant clinical findings, the decisions made, the information given to patient's and any drugs or other treatment prescribed". The lack of clinical examination both on admission and more important Mrs Gregory care deteriorated represents poor clinical practice to the standards set by the General Medical Council.

Despite the above I am satisfied that Mrs Gregory's death was of natural causes and that her overall clinical management in Gosport

was just adequate.

8 LITERATURE/REFERENCES

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9. EXPERTS' DECLARATION

1. I understand that my overriding duty is to the court, both in preparing reports and in giving oral evidence. I have complied and will continue to comply with that duty.
2. I have set out in my report what I understand from those instructing me to be the questions in respect of which my opinion as an expert are required.
3. I have done my best, in preparing this report, to be accurate and complete. I have mentioned all matters, which I regard as relevant to the opinions I have expressed. All of the matters on which I have expressed an opinion lie within my field of expertise.
4. I have drawn to the attention of the court all matters, of which I am aware, which might adversely affect my opinion.
5. Wherever I have no personal knowledge, I have indicated the source of factual information.
6. I have not included anything in this report, which has been suggested to me by anyone, including the lawyers instructing me, without forming my own independent view of the matter.
7. Where, in my view, there is a range of reasonable opinion, I have indicated the extent of that range in the report.
8. At the time of signing the report I consider it to be complete and accurate. I will notify those instructing me if, for any reason, I subsequently consider that the report requires any correction or qualification.

9. I understand that this report will be the evidence that I will give under oath, subject to any correction or qualification I may make before swearing to its veracity.
10. I have attached to this report a statement setting out the substance of all facts and instructions given to me which are material to the opinions expressed in this report or upon which those opinions are based.

10. STATEMENT OF TRUTH

I confirm that insofar as the facts stated in my report are within my own knowledge I have made clear which they are and I believe them to be true, and the opinions I have expressed represent my true and complete professional opinion.

Signature:_____ Date: _____