Field Fisher Waterhouse

GENERAL MEDICAL COUNCIL

-and-

DR BARTON

SHEILA GREGORY

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GENERAL MEDICAL COUNCIL

DR BARTON

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Operation ROCHESTER.

Key points July 2006.

Sheila GREGORY born **Code A**

Sheila GREGORY was one of nine children raised in the Shaftsbury area of Dorset. In 1943 she married her husband William there was one child from the marriage. The couple retired to a caravan in Weymouth. Following William's death in 1984 Mrs GREGORY moved to warden controlled premises in Gosport, Hampshire in 1990.

Mrs GREGORY suffered several chronic medical conditions during her lifetime including a heart attack in her 30's and a second similar attack in her 60's. She was a heavy smoker until ten years prior to her death suffering associated breathing problems for which she used an inhaler and had been admitted to hospital for a period of a month in 1989.

Additionally she suffered an under active thyroid and thin delicate skin that would damage very easily. She was an insomniac.

In 1995 Mrs GREGORY attended a geriatric day hospital under the care of a consultant geriatrician. A number of medical problems were identified including suffering headaches and heart problems.

She regularly attended her GP surgery in Gosport, four monthly between 1996 and 1999. Her GP Dr HARRISON recorded that she was suffering with chronic obstructive pulmonary disease which she had had for many years secondary to smoking, valvular heart disease and mild anxiety state leading to insomnia.

By December 1998 Mrs GREGORY was extremely unwell she was admitted to Haslar Hospital Gosport with chronic airways disease and left ventricular failure. Whilst in severe respiratory failure, she recovered enough to be declined social services intervention.

In February 1999 she was reviewed at outpatients for breathlessness, an X-ray of December 1998 confirmed that she was in heart failure.

On 15th August 1999 Mrs GREGORY was admitted to Haslar Hospital following a fall sustaining a fractured neck of the femur. The injury was dealt with by way of dynamic hip screw operation performed by Dr MISRA without complication.

Her recovery was 'uneventful' she was described as unmotivated she suffered a swollen right leg, and was suffering chronic confusion and diarrhoea.

On 24th August 1999 consultant geriatrician Dr TANDY decided to transfer her to Gosport War Memorial hospital, accordingly she was transferred on 3rd September 1999 at that time using a Zimmer frame, being catheterised and doubly incontinent, suffering asthma, heart failure and allergy to penicillin. Mrs GREGORY also remained confused.

Upon transfer to Dryad Ward Gosport War Memorial hospital a 20 bed ward, Mrs GREGORY was seen by Dr Jane BARTON who noted her condition as a fractured neck of the femur, history of hypothyroidism, asthma and cardiac failure. Dr BARTON added that the plan was to get to know her and gentle rehabilitation. The record requested that nurses make her comfortable and added that Dr BARTON was happy for nursing staff to confirm death.

Any pain present was satisfactorily controlled by co-dydramol twice a day and paracetamol.

On 6th September 1999 Mrs GREGORY is noted to have had a resolved left sided facial droop and tenderness to her right wrist. She was administered aspirin for her atrial fibrillation.

At this stage she was heavily dependent in terms of care and a high risk of suffering pressure sores.

Mrs GREGORY was then regularly reviewed both by Dr BARTON and Consultant Dr REID and was noted to be suffering poor appetite, agitation, variable confusion and with no significant improvement in mobility, she remained catheterised and faecally incontinent.

The lack of progress in rehabilitation continued, on the 1st November 1999 she vomited, between the 15th and 18th November 1999 she further deteriorated suffering chest infection and nausea. There followed a marked deterioration of her general condition nursing notes describing her as quite distressed and breathless.

Dr BARTON authorised small doses of oral opiates to make the patient comfortable and recorded that she was happy for nursing staff to certify death.

The final drug chart from the 18th November until 22nd November showed that Oramorph (an oral opiate) was administered six hourly on the 18th/19th November, and Diamorphine 20mgs in 24hrs on 20th and 21st November 1999.

Mrs GREGORY further declined between the 19th and 22nd November 1999 and she died at 1720hrs on 22nd November her death being verified by Nurses SHAW and HAMBLIN.

Dr BARTON certified the cause of death as Bronchopneumonia.

Clinical team assessment.

Mrs GREGORY died 81 days after admission to Gosport War Memorial Hospital. She had suffered a fractured neck of the femur and other medical problems. The original aim was rehabilitation, but there was an early entry about keeping her comfortable. There was a suggestion of a stroke early in her stay at GWMH and she deteriorated. The decision was made to refer her to Nursing Home for care because she was unlikely to improve further. She then deteriorated with distress and breathlessness. The staff wondered about a chest infection but did not start antibiotics. Oromorph helped the distress and breathlessness, so she was started on a reasonably low dose of diamorphine through a syringe driver. Frusemide as a diuretic was given in case the breathlessness was due to fluid on the lungs. In the end the cause of death was not entirely clear (recorded as Bronchopneumonia) Should they have tried antibiotics or explained why they were not used? She probably would have died whatever was done from 15.11.1999.

Account Dr Jane BARTON from interview with police 25th August 2005.

Within a prepared statement Dr BARTON outlined the medical history of the patient Mrs GREGORY prior to her admission to Gosport War memorial hospital on 3rd September 1999.

Dr BARTON noted Mrs GREGORY's condition and recorded that she was significantly dependent. In accordance with her usual practice she noted that she was happy for nursing staff to confirm death, this meaning that she wanted to ensure that nursing staff were aware that it was not necessary for a doctor to be called out if the patient were to die and a doctor were not available at the hospital at the time. Dr BARTON had hoped that rehabilitation might prove possible but recognised the trauma of the fracture, the operation, the hospital transfer and her other medical problems there being a clear possibility therefore for deterioration in her condition.

Dr BARTON prescribed medication in the form of Co-Dydramol and Oramorph for pain relief and a variety of other drugs to assist her with her other ailments.

In addition Dr BARTON prescribed Diamorphine at a range of 20 – 200mgs, Hyoscine 200 -800 mcgs and Midazolam 20 -80 mgs to be available via syringe driver if necessary.

Dr BARTON anticipates that she would have been available to review Mrs GREGORY'S condition day by day each week, she was not able to make notes of routine assessment due to pressure of work however the consultant Dr REID was making a weekly note following ward round assessment.

Clinical team assessment.

Mrs GREGORY died 81 days after admission to Gosport War Memorial Hospital. She had suffered a fractured neck of the femur and other medical problems. The original aim was rehabilitation, but there was an early entry about keeping her comfortable. There was a suggestion of a stroke early in her stay at GWMH and she deteriorated. The decision was made to refer her to Nursing Home for care because she was unlikely to improve further. She then deteriorated with distress and breathlessness. The staff wondered about a chest infection but did not start antibiotics. Oromorph helped the distress and breathlessness, so she was started on a reasonably low dose of diamorphine through a syringe driver. Frusemide as a diuretic was given in case the breathlessness was due to fluid on the lungs. In the end the cause of death was not entirely clear (recorded as Bronchopneumonia) Should they have tried antibiotics or explained why they were not used? She probably would have died whatever was done from 15.11.1999.

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Dr BARTON pointed out that the patient was reviewed by Consultant Dr REID on the 13th/20th/27th September 1999, 4th/11th/18th/25th October 1999 and 1st/8th and 15th November 1999.

Dr BARTON commented that Dr REID would have reviewed the prescription chart when conducting his weekly ward round and would have been aware that Dr BARTON had consistently written up drugs to be available 'as necessary'.

Dr BARTON was abroad from 12th to 16th November 1999.

Dr REID noted on examination of 15th November 1999 that Mrs GREGORY had become frailer being less well with a chest infection.

The nursing record of the 17th November showed that Mrs GREGORY continued to deteriorate being unwell distressed and breathless, as a consequence Dr BARTON wrote up a prescription for Oramorph.

On the 18th November Dr BARTON recorded the further deterioration, she was concerned that Mrs GREGORY might die and was anxious to speak to the granddaughter to warn her.

Dr BARTON wrote up further prescriptions for Diamorphine, Hyoscine, Midazolam and Cyclizine, on the 19th November she became concerned that the patient was developing congestive cardiac failure.

In view of the continued deterioration it was appropriate to change from repeated administrations of Oramorph to Diamorphine via syringe driver.

Dr REID recorded further deterioration on 22nd November 1999 and that the Diamorphine should continue.

The Diamorpohine and Oramorph that preceded it was prescribed by Dr BARTON and administered solely with the intention of relieving the shortness of breath Mrs GREGORY was experiencing from what Dr BARTON believed to be her cardiac failure and the anxiety and distress that Mrs GREGORY was suffering as a consequence.

Dr BARTON concluded that at no time was the medication provided with the intention of hastening Mrs GREGORY's demise.

<u>Expert Witness Dr Andrew WILCOCK (Palliative medicine and medical oncology) will say:-</u>

Mrs Gregory's decline was noted over a number of weeks and this would be in keeping with a natural decline into a terminal phase. Further, whatever the reason was for the use of Diamorphine, the physical findings on the day of Mrs Gregory's death would suggest that the dose she was receiving was

unlikely to have been excessive to the degree that it rendered her unresponsive or was associated with respiratory depression.

Expert Witness Dr David BLACK (Geriatrics) comments:-

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 his 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.

As is all too common, a very frail elderly lady had a fall and she suffered a fractured neck of femur. She was 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.

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

She was subsequently assessed by the geriatric team and appropriately transferred to Gosport Hospital. The comment in the notes in Haslar, "will get home?" suggest that a consultant view was that even at this early stage, significant improvement was very unlikely, a view agreed by Dr BLACK.

When transferred to the Gosport War Memorial Hospital Mrs Gregory was seen by Dr Barton who failed to record a clinical examination apart from some short statements about her past medical history and her functional history. However, Mrs Gregory appeared to have been in a relatively stable clinical condition and no harm seemed to befall her as a result of this failure to examine her.

However, she was 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.

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

placement.

On 15th November she is noted to be quite unwell, the diagnosis was not entirely clear and Dr BLACK wondered whether something was actually starting on 1st November when there was an episode of vomiting. The patient was examined and that examination is recorded in the notes. However, by 18th November, she had very rapidly deteriorated and Dr Barton made 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 making no significant progress after 3 months in hospital. A symptomatic response to this lady's problems was a reasonable clinical decision.

She received 5 mgs 6 hourly of Oramorphine on the 18th and 19th December, which Dr BLACK believed to be an appropriate dosage and therapeutic regime. No improvement was made and she started on a 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 was made on that day, however Dr BLACK believed this to have been a reasonable decision for a patient who was dying.

Diamorphine was 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.

Seen on the 22nd, she was very ill with a rapid pulse, a rapid respiratory rate with a clear sounding chest. This suggests to Dr BLACK 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.

A remaining concern regarding the clinical management was 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.

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 Dr BLACK was satisfied that Mrs Gregory's death was of natural causes.

Evidence of other key witnesses.

Janet Martin-Rogers (Mrs GREGORY'S daughter) Detailed medical history and background as known. His mother was heavy smoker, smoked 40 cigarettes a day. Following fractured hip in April 1999 mother was admitted to Queen Alexandra and then Gosport War memorial hospital. Seemed to be making progress but worsened after her bout of diarrhoea.

Pauline GREGORY (granddaughter) Details family history, following her admission to Haslar hospital in 1999 Pauline asked for a move to Gosport War Memorial hospital because she felt that she would receive rehabilitative treatment. Her grandmother was initially very happy she thought the nurses were lovely and she made progress. Then declined, not eating or drinking much and staying in bed. On 20th November Mrs GREGORY was happy bright alert and lucid, did not complain of any pain. By 21st November she was lying on her side and appeared drowsy.

Dean GREGORY (great grandson) General background information made several visits to Mrs GREGORY at GWMH. Was telephoned by a nurse on 22nd November to 'come in and say good-by', does not know why she died, she was a strong fit woman who had broken her hip.

Luci GREGORY (great granddaughter) Background as above.

Trudi JACKSON (granddaughter) Background.

Code A (G.P retired) Principal in general practice at Bury Road Surgery, GOSPORT. Mrs GREGORY a patient since 1984. Initially attended infrequently but then every four months between 1996 and 1999.
Mrs GREGORY was on long term medication for an under active thyroid gland and a hypnotic as she was an insomniac. She was suffering fromchronic obstructive pulmonary disease secondary to smoking, valvular heart disease and mild anxiety leading to insomnia. As a result her routine medicine was:-
Thyroxine- For under-active thyroid.
Salbutomal, Beclaforte inhaler and Atrovent – for chronic obstructive pulmonary disease.
Zimovane-for insomnia.
Attended Mrs GREGORY's home address 15th December 1998 breathless and could not lay down, diagnosed pneumonia in left lung and left ventricular failure and arranged admission to Queen Alexandra Hospital forthwith.

Code A (GP Retired) Gosport surgery.. saw Mrs GREGORY several times between 1986 and 1999 (22 occasions) for various ailments including, back pain, conjunctivitis, chest infections, sore mouth, dizziness, urinary tract infection, leg injury, falling and low pulse, headaches and lack of energy.

Code A (Consultant Orthopaedic Surgeon (retired)
On 16th August 1999 supervised the dynamic hip screw procedure to Mrs GREGORY's fractured neck of the femur, a routine operation with no complications. Then conducted 4 ward rounds between 18th and 31st August the patient progressed well and plan to transfer to GWMH for rehabilitation.

Code A (Senior House Officer Orthopaedics) post operative care Mrs GREGORY 25th August 1999 to 1st September 1999. Detailed notes indicate satisfactory progress in the patient over this period.

Code A (Clinical ward manager Haslar Hospital) Ward consisted of 20 beds with 20 staff on 24hr rota. Mr TOLLEY wrote Mrs GREGORY's discharge letter of 3rd September 1999.

Richard REID (36 page statement) (Consultant Geriatrician)
Supervised Dr Jane BARTON at GWMH. Detailed notes of weekly ward rounds in respect of Mrs GREGORY from 13th September 1999 to 15th November 1999.
Felt it was inappropriate for Dr BARTON to prescribe Diamorphine, Midazolam and Hyoscine on 3rd September 1999 in the absence of documented pain or distress and in the absence of documentation that Mrs GREGORY was terminally ill.
However it was appropriate for Dr BARTON to prescribe opiates on 20th November 1999, it was common in patients in the terminal stages of life to clear secretions gathering in the upper airway and acceptable medical practice.
Dr REID had once challenged Dr BARTON about variable dosages, she was not happy about being challenged and gave any explanation that she was not always available for patients that develop severe pain or distress and nurses would be able to administer appropriate medication in a timely way to relieve pain and suffering.
Dr REID trusted nurses to use discretion with variable doses appropriately. He did not recollect anything other than the minimum doses being administered.
Whilst cause of death was recorded as bronchopneumonia there was no specific record as such within the medical notes.
Whilst Dr BARTONS not keeping may have been poor due to pressures of work it was Dr REID'S view that patients were being appropriately medically managed by her.

Arumugam RAVINDRANE (Consultant physician elderly medicine) Describes the process of consultant ward rounds conducted with Dr REID. Conducted such a round with Dr REID and Mrs GREGORY on 6th September 1999.

Code A (Consultant Radiologist) examined Mrs GREGORY's x-rays 7th September 1999 (taken 15.8.99) fractured femur, bones generally osteoporotic thin and brittle and degeneration to the wrist.

Jeanette FLORIO (Nurse GWMH) History re syringe driver training/application. Employed Dryad Ward, wrote patient admittance summary in respect of Mrs GREGORY and patient care plan.

Gillian HAMBLIN (Clinical Manager Dryad Ward GWMH) responsible for 24hr care of patients Dryad Ward. Information re ward routines.
Administered Oramorph 17.11.99.
Completed drug register entries in respect of administration of Diamorphine and Oramorph.
Counter-signes death verification entry in respect of Mrs GREGORY.

Lynne BARRET (Nurse GWMH) Background re procedure/use of syringe drivers, ward rounds, and general entries on the nursing record pertaining to Mrs GREGORY. Recorded that patient not very well distressed and breathless on 17.11.99 and unwell on 18.11.99. Witnessed nurse HAMBLIN administer Oramorph.

Elizabeth BELL (Carer GWMH) General nursing entries.

Code A (Nurse GWMH) Background re syringe drivers ward rounds and general nursing entries through Mrs GREGORY's tenure at GWMH. Administered 20mgs diamorphine to Mrs GREGORY on 21.11.99.

Freda SHAW (Nurse GWMH) Background re syringe driver procedure, ward round practices, various nursing note entries in respect of Mrs GREGORY including verification of death.

Irene DORRINGTON (Nurse GWMH) General nursing note entries.

Christine EVANS (Nurse GWMH) General nursing note entry.

Christopher YATES (Detective Constable) Re interview Dr BARTON 25th August 2005.

D.M.WILLIAMS
Detective Superintendent 7227
24th July 2006.

Background/family observations

Sheila GREGORY was born [Code A] She was one of nine children and lived just outside Shaftesbury in Dorset, she married William GREGORY on 4th June 1934 and had one daughter. [Code A] [Code A]. She was a small, slight lady. When William retired they moved to a caravan in Weymouth and then to Lee-on-the-Solent. William died in 1984 and Sheila continued to live in the caravan alone until approximately 1990 when she moved into a warden assisted flat in Gosport.

Mrs GREGORY suffered a heart attack in her 30's and probably another one in her 60's. She was a heavy smoker and as a result suffered from emphysema which led to ongoing breathing problems for which she would use an inhaler. She stopped smoking 10 years prior to her death. She had an under active thyroid for which she took tablets and very thin, delicate skin that would bleed and bruise very easily, which the district nurse would attend to every week.

In 1989 Mrs GREGORY was admitted to Haslar Hospital, with breathing problems, where she stayed for approximately one month.

In mid 1999 Mrs GREGORY fell and broke her hip. She was admitted to Haslar Hospital and had it pinned under local anaesthetic, due to her breathing problems. Her recovery was not as fast as other patients and after about four weeks was transferred to Gosport War Memorial Hospital for rehabilitation.

Initially Mrs GREGORY was very happy at Gosport War Memorial Hospital, she was mobile although could not walk far and did have some pain in her hip, was eating, drinking and making progress. There was then a change in Mrs GREGORY. She would stay in bed, had a catheter fitted, was still suffering pain from her hip and would avoid doing her physio. When the nursing staff were challenged they replied "Because she doesn't want to get up", she then didn't eat or drink much and again when the staff were asked about this replied "They don't make them eat if they don't want to" and "They are at the time of their life that they can do as they please".

Mrs GREGORY had a tube put into her stomach for pain killers, she was full up and bored and said that she "had had enough". Although this didn't concern her family as she was always saying things like that.

Some days she was slumped and depressed, others cheerful and chatty. At this time the family's expectation was that she would leave hospital by Christmas.

On Saturday 20th November 1999 Mrs GREGORY was happy, bright and alert. She didn't complain of being in pain nor did she appear to be suffering any pain.

On Sunday 21st November 1999 she was lying on her side, drowsy and not with it.

On Monday 22nd November 1999 Mrs GREGORY was unconscious and when her hand was held did not wake up or stir. At 5.30pm (1730) that day Mrs GREGORY died.

The family were of the opinion that the circumstances of Mrs GREGORY was not right and that she died very suddenly.

Mrs GREGORY was buried at Code A

Sequence of Mrs Shelia GREGORY medical history.

Sheila GREGORY a 91 year-old lady in 1999 was admitted as an emergency on 15th August 1998 to Haslar Hospital.

She had a number of chronic conditions including a partial Thyroidectomy and Hypertension. In 1990 she was admitted with acute on chronic episode of obstructive airways disease. In 1991 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. (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, slow atrial fibrillation, left ventricular failure and mitral regurgitation confirmed by an echo cardiogram. She has an episode of diplopia and is noted to have marked bruising.

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.

In December 1998 she is admitted severely ill to Haslar Hospital with chronic airways disease and left ventricular failure. She is in severe respiratory failure with a measured partial pressure of carbon dioxide (pCO2) of 12.6. However, she does recover and on this admission is declined Social Services intervention. In February 1999 she is reviewed in outpatients for episodic breathlessness. A chest x-ray in December 1998 confirms that she had heart failure.

On 15th August 199 she is admitted with a fractured proximal right femur and has a dynamic hip screw performed on 16th August. 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. On 27th August her right leg is noted to be swollen and is started on Erythromycin. On 1st September it is still swollen.

In the meantime she has been referred to the geriatric team and is seen on 24th August. 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?"

She is transferred on 3rd September 1999 to Gosport and the letter from Haslar 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.

The notes on transfer to Dryad Ward (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".

On 6th September 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. At this stage her Barthel is 2 (very heavily dependent) with a Waterlow score of 35 identifying that she at very high risk of pressure sores.

She is then reviewed regularly on the ward with comment most weeks. 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 test and thyroid function test are all unremarkable, her weight on 22nd October is 45.3 kgs.

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

On 15th November 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 there is marked deterioration in her general condition. This is also noted in the nursing cardex, 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.

On 19th November, nursing cardex reports her as poorly but stable.

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 HAMBLIN.

There are three main drug charts in the notes for her stay in Gosport. The first is from the 3rd September to 6th October. 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.

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.

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. 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.

Dr Jane BARTON

The doctor on a day to day basis for the treatment and care of Shelia GREGORY was a Clinical Assistant. As such her role in caring for patients is governed by Standards of Practice and Care as outlined by the General Medical Council. The medical care provided by Dr BARTON to Mrs GREGORY during her transfer to Dryad Ward, Gosport War Memorial Hospital is suboptimal when compared to the good standard of practice and care expected of a doctor outlined by the General Medical Council, Good Medical Practice, October 1995, (pages 2–3)

The medical records were examined by two independent experts.

Dr David BLACK reports :-

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's 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.

Dr Andrew WILCOCK's report is awaiting completion although he has reviewed Mrs GREGORY's medical notes and reports :-

- In summary, pain did not appear to be a major problem for Mrs Gregory at the time of her transfer to Dryad Ward. Any pain present appeared satisfactorily controlled with p.r.n. doses of co-dydramol 2 tablets, twice a day at most. During Mrs Gregory's time on Dryad Ward, she appears to have experienced a number of pains. Apart from the pain in the right wrist, no medical assessment is documented and their underlying cause is unclear. Nevertheless, they were generally treated with paracetamol only. Thus, in my opinion, from a pain point of view, there was no justification for the prescription of diamorphine, hyoscine and midazolam to be given in a syringe driver on the day that she was transferred to Dryad Ward and when the drug chart was rewritten on the 18th November 1999. However, she did not receive any diamorphine until 20th November 1999. One obvious conclusion, that should be explored further, is that the use of these drugs, in these doses, was part of a 'standard' approach, that had little, if any, immediate consideration or relevance to an individual patient. The reasoning behind such an approach should be identified.
- In my opinion, from a pain point of view, there was no justification for the prescription of the regular oral morphine on the 18th November 1999 and the indication for its use needs to be determined. If it was for anxiety, as the nursing notes suggest, this in my opinion is not an appropriate use of morphine. However, opioids are indicated for the relief of symptoms other than pain, e.g. cough and breathlessness, and Mrs Gregory did have breathlessness. In my experience, morphine is widely used to relieve breathlessness (generally occurring at rest) in patients with cancer. It is used less in non-cancer conditions causing breathlessness, although this practice may be increasing. Nevertheless, it is generally used for symptomatic relief of breathlessness that persists despite the optimal treatment of the underlying cause. In this regard, there is a lack of documentation in the medical notes that an assessment was made of Mrs Gregory's medical condition around the times that breathlessness seemed a particular problem, e.g. 17th and 19th November 1999. If a thorough medical assessment of Mrs Gregory's breathlessness on the 17th November 1999 had considered it to be due to heart failure, then appropriate management of her heart failure could be seen as a more appropriate response to her episodes of breathlessness and anxiety rather than the use of morphine per se. On the 19th November 1999, a stat dose of frusemide 40mg was given IM at 15.45h because of breathlessness. In my experience, it is generally the case that a patient who is considered to be a degree of heart failure sufficient to warrant parenteral frusemide, also warrants a medical review. Given this occurred at 15.45h, I would have considered it appropriate for Dr Barton/the doctor on call to have assessed Mrs Gregory as soon as was possible the same day, and not to have left until the following morning. Even so, there was no medical notes entry for 20th November 1999, although regular oral frusemide 40mg once a day was presc\\ribed. I am not a cardiologist however, and the opinion of one could be sought if considered necessary regarding the above.

- The use of a syringe driver with an anti-emetic was reasonable, given that Mrs Gregory was experiencing nausea and vomiting, and this is an indication for its use. The appropriateness of the use of diamorphine depends on the indication for the oral morphine.
- However, the above issues aside, Mrs Gregory's decline was noted over a number of weeks and this would be in keeping with a natural decline into a terminal phase. Further, whatever the reason was for the use of diamorphine, the physical findings on the day of Mrs Gregory's death would suggest that the dose she was receiving was unlikely to have been excessive to the degree that it rendered her unresponsive or was associated with respiratory depression.

Interview of Dr Jane BARTON

Dr Jane BARTON has been a GP at the Forton Medical Centre in Gosport since 1980, having qualified a registered medical practitioner in 1972. In addition to her GP duties she took up the post of the sole Clinical Assistant in elderly medicine at the Gosport War Memorial hospital in 1988. She resigned from that post in April 2000.

On Thursday 25th August 2005 Dr BARTON, in company with her solicitor, Mr BARKER, voluntarily attended Hampshire Police Support Headquarters at Netley where she was interviewed on tape and under caution in respect of her treatment of Shelia GREGORY at the Gosport War Memorial hospital.. The interviewing officers were DC Christopher YATES and DC Geoff QUADE.

The interview commenced at 0900 and lasted for 33 minutes. During this interview Dr BARTON read a prepared statement, later produced as JB/PS/8.

This statement dealt with the specific issues surrounding the care and treatment of Shelia GREGORY.

The expert response to Dr BARTON's statement is awaiting completion

DRAFT OVERVIEW

OF

SHEILA GREGORY (BJC/21 and JR/12)

PREPARED BY: Dr Andrew Wilcock MB ChB FRCP DM
Reader in Palliative Medicine and Medical Oncology

AT THE REQUEST OF: Hampshire Constabulary

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1. INSTRUCTIONS

2. DOCUMENTATION

3. COMMENTS

4. CONCLUSION

1. INSTRUCTIONS

To examine and provide a preliminary overview of the case of Sheila Gregory.

2. DOCUMENTATION

This Report is based on the following documents:

[1] Full paper set of medical records of Sheila Gregory (BJC/21 and JR/12).

[2] Full set of medical records of Sheila Gregory on CD-ROM (BJC/21).

[3] Hampshire Constabulary summary of care of Sheila Gregory.

3. COMMENTS

Note: These comments are based on a preliminary read through the case notes of Sheila Gregory. They are made without prejudice and a more detailed review may produce a report with differing comments and conclusions.

For brevity and in keeping with the purpose of this overview I have restricted my comments under the following sub-headings.

Was pain clearly documented as a problem and assessed?

On the 15th August 1999, Mrs Sheila Gregory fell and fractured her right hip (neck of femur) and was admitted to the Royal Hospital Haslar. The fracture was treated surgically with a dynamic hip screw on the 16th August 1999. For postoperative analgesia, Mrs Gregory required occasional doses of 'weak' opioid analgesics as required (p.r.n.); initially she took no more than two doses of tramadol 100mg (which may have worsened her confusion) and subsequently co-dydramol (2 tablets; each tablet contains paracetamol 500mg and dihydrocodeine 10mg) per day. Pain did not appear to be a problem when Mrs Gregory was reviewed by Dr Tandy on the 24th August 1999, nor in the transfer

letter written on the day of her transfer to Dryad Ward on the 3rd September 1999, at which time she was mobilising with a zimmer frame and the help of one other person. There was no mention of pain as a problem in the medical or nursing notes on her transfer to Dryad Ward. On an assessment sheet, which although undated appears as to have been filled in at the time of her transfer, the section on pain is completed to suggest that pain was present but controlled (page 243 of 346).

On the 6th September 1999, the medical notes record that Mrs Gregory had pain and tenderness in the right 'snuff box' (wrist). This could have been injured when she fell, and an X-ray was carried out to exclude a fracture. I presume it was because of this wrist pain, that paracetamol was commenced regularly (1G four times a day) and continued until 23rd October 1999, after which the administration became erratic. There was no further mention of any pain in the medical notes. In the nursing care plan, other mentions of pain were:

- 22nd October 1999 - indigestion, given Gaviscon (an antacid)
- 25th October 1999 - pain in the right leg, given paracetamol
- 16th November 1999 - 'discomfort', site not specified, given paracetamol
- 17th November 1999 - pain in neck (followed by unintelligible word ?arm; page 204/346), given paracetamol
- 19th November 1999 - breathless and pain in shoulder, given frusemide (a diuretic) but no additional analgesia. Was receiving regular morphine at this point.

Apart from the pain in the right wrist, no medical assessment is documented and the underlying cause of these other pains is unclear. Nevertheless, they were generally treated with paracetamol only.

Was the management of the pain appropriate?

On her transfer to Dryad Ward on the 3rd September 1999, Mrs Gregory was prescribed 2 co-dydramol tablets p.r.n., as at Royal Hospital Haslar. In my opinion, this was appropriate.

She was also prescribed oral morphine (Oramorph) 5–10mg every 4h p.r.n. It is unclear from the medical notes why this was considered necessary, particularly as Mrs Gregory had only been requiring occasional doses of co-dydramol. Some practitioners do use small doses of morphine rather than dihydrocodeine, and although a dose of 5–10mg is in keeping with the BNF recommendations, given Mrs Gregory's advanced age, a dose of morphine 2.5mg p.r.n. may well have sufficed. It would also have equated more closely to her dose of co-dydramol; morphine is 10 times more potent as dihydrocodeine and hence two tablets of co-dydramol (20mg dihydrocodeine) is equivalent to 2mg morphine.

On the day of her transfer, Mrs Gregory was also prescribed diamorphine 20–200mg SC/24h, hyoscine (hydrobromide) 200–800microgram SC/24h and midazolam 20–80mg SC/24h by syringe driver. There is nothing documented that supports the prescription of these drugs; at the time of her transfer there was no suggestion that Mrs Gregory had symptoms that required these drugs in these doses. Further, the medical plan for Mrs Gregory was for gentle rehabilitation. However, Mrs Gregory did not receive any diamorphine by syringe driver until 20th November 1999.

The subsequent prescription and administration of opioids does not appear to have been primarily for pain, and the exact reason for their use should be clarified. On the 17th November 1999 the nursing summary notes record that Mrs Gregory was not very well in the evening and was becoming quite distressed and breathless at times and that morphine 5mg was given to relieve

her distress with good effect. In my opinion, opioids are not indicated as a non-specific treatment of 'distress.' If Mrs Gregory was distressed because of her breathlessness, it would have been most appropriate to have first assessed and treated any underlying cause, when possible and appropriate. There are many reasons why someone may become breathless, many of which are relevant given Mrs Gregory's past medical history, e.g. chest infection, asthma/chronic obstructive airways disease, atrial fibrillation and heart failure. The latter may be particularly relevant as Mrs Gregory's only heart failure treatment she had been receiving (captopril) was discontinued at Haslar, possibly because of low blood pressure peri-operatively.

On the 18th November 1999, she was seen by Dr Barton, and the medical notes conclude that Mrs Gregory may have had a further CVA (cerebrovascular accident; a stroke), although the medical history/physical findings that led to this conclusion are not documented. There was no documentation of breathlessness or distress, and no documentation that a physical examination had taken place. Oral morphine was commenced regularly (5mg every four hours and 10mg at night). The nursing summary note seems to indicate that the morphine was commenced because Mrs Gregory was feeling anxious. In my opinion, this is not an appropriate use of morphine.

The drug chart was rewritten on the 18th November 1999, and again included prescriptions for diamorphine (now in a range of 20–80mg SC/24h), hyoscine (hydrobromide) 200–800microgram SC/24h and midazolam 20–80mg SC/24h by syringe driver. On the afternoon of the 20th November 1999, a syringe driver was commenced containing diamorphine 20mg and cyclizine (an anti-emetic) 50mg SC over 24h. This was continued on the 21st November 1999 and Mrs Gregory died at 17.20h. Mrs Gregory had been experiencing nausea and

vomiting and this is an indication for the use of a syringe driver containing an anti-emetic. The cyclizine was prescribed as a range (50–200mg/24h) but I note Mrs Gregory received a stat dose of 50mg at 13.15h on 20th November 1999. The dose in the syringe driver (50mg/24h) was smaller than that generally given (150mg/24h). In order to comment on the appropriateness of the use of the diamorphine, clarification is required on the indication for the oral morphine.

Were excessive doses of morphine/diamorphine/midazolam administered?

In my opinion, on the day of her transfer, the prescription of diamorphine 20–200mg SC/24h and midazolam 20–80mg SC/24h by syringe driver appears unnecessary and inappropriate. However, Mrs Gregory did not receive any diamorphine by syringe driver until 20th November 1999.

On the 18th November 1999, Mrs Gregory was seen by Dr Barton and commenced on oral morphine 5mg every 4h and 10mg at night. The reason for this should be clarified. It is not unusual for a double dose to be given at 22.00h, to try and avoid the need for a 02.00h dose. This starting dose is in keeping with the BNF (i.e. 30mg/24h). However, given Mrs Gregory's advanced age, a smaller dose may well have sufficed and would have been more appropriate in my opinion (i.e. 15mg/24h). Mrs Gregory received this dose of oral morphine for 48h, between the 18–20th November 1999.

The drug chart was rewritten on the 18th November 1999 and again included prescriptions for diamorphine 20–80mg SC over 24h, hyoscine and midazolam. Mrs Gregory commenced a syringe driver containing 20mg of diamorphine on the 20th November at 17.00h. To calculate an appropriate dose of SC diamorphine, the daily oral morphine dose is divided by 2 or more generally 3. Given that Mrs Gregory had been receiving 30mg/24h of oral morphine, her SC

diamorphine dose should thus have been 10–15mg/24h rather than the 20mg/24h she received. Although these figures do not differ greatly, they may be important in an elderly patient and it should be ascertained how Dr Barton calculated or determined that the dose of diamorphine 20mg/24h was appropriate for Mrs Gregory.

Was the death of the patient anticipated?

Mrs Gregory was a frail 91 year old with significant medical problems, namely heart failure, atrial fibrillation and a probable cerebrovascular accident (CVA) who had fell and fractured her right hip. She was confused at times. Following transfer to Dryad ward Mrs Gregory was slow to mobilise. She possibly sustained a further small stroke causing the left side of her face to droop and her to lean to the left when standing. Her mobility failed to improve significantly. On the 27th September 1999, she was noted to be 'generally less well' and on the 11th October 1999, 'very dependent and delightfully (usually) confused' and the aim then became nursing home placement. On the 15th November 1999, she was noted to be frailer, less well and to have a chest infection. She also had occasional bouts of nausea. On the 18th November 1999, a further deterioration in Mrs Gregory's general condition was noted and it was considered that she may have had a further CVA. She was commenced on oral opioids for a reason that remains to be clarified. Mrs Gregory subsequently declined further and was commenced on a syringe driver on the 20th November 1999 and died on the 22nd November 1999 at 17.20h. Earlier on that day, Mrs Gregory was reviewed by Dr Reid, who noted her to be able to give short verbal responses, to have a respiratory rate of 24 breaths/min and her chest clear at (unintelligible word; page 70/346).

Thus, Mrs Gregory's physical decline had been documented over several weeks. Part of her deterioration appeared to have been the symptom of breathlessness. It is unclear from the medical notes, what the underlying cause of this was, although it may have been multifactorial; Mrs Gregory had asthma/chronic obstructive airways disease, heart failure and a chest infection. The use of frusemide IM and subsequently orally does suggest that heart failure was considered to be a contributing factor. Contrary to this would be the finding of a clear chest on the 15th and the 22nd November 1999; in heart failure generally crackles, caused by excess fluid, are audible in the chest.

The reason for the prescription of the oral morphine and subsequently the diamorphine remains to be clarified. However, the fact that Mrs Gregory was capable of responding and had a respiratory rate of 24 breaths/min suggests that the dose of diamorphine she was receiving was not excessive to the point of rendering her unresponsive or depressing her respiration.

4. CONCLUSION

In summary, pain did not appear to be a major problem for Mrs Gregory at the time of her transfer to Dryad Ward. Any pain present appeared satisfactorily controlled with p.r.n. doses of co-dydramol 2 tablets, twice a day at most. During Mrs Gregory's time on Dryad Ward, she appears to have experienced a number of pains. Apart from the pain in the right wrist, no medical assessment is documented and their underlying cause is unclear. Nevertheless, they were generally treated with paracetamol only. Thus, in my opinion, from a pain point of view, there was no justification for the prescription of diamorphine, hyoscine and midazolam to be given in a syringe driver on the day that she was transferred to Dryad Ward and when the drug chart was rewritten on the 18th

November 1999. However, she did not receive any diamorphine until 20th November 1999. One obvious conclusion, that should be explored further, is that the use of these drugs, in these doses, was part of a 'standard' approach, that had little, if any, immediate consideration or relevance to an individual patient. The reasoning behind such an approach should be identified.

In my opinion, from a pain point of view, there was no justification for the prescription of the regular oral morphine on the 18th November 1999 and the indication for its use needs to be determined. If it was for anxiety, as the nursing notes suggest, this in my opinion is not an appropriate use of morphine. However, opioids are indicated for the relief of symptoms other than pain, e.g. cough and breathlessness, and Mrs Gregory did have breathlessness. In my experience, morphine is widely used to relieve breathlessness (generally occurring at rest) in patients with cancer. It is used less in non-cancer conditions causing breathlessness, although this practice may be increasing. Nevertheless, it is generally used for symptomatic relief of breathlessness that persists despite the optimal treatment of the underlying cause. In this regard, there is a lack of documentation in the medical notes that an assessment was made of Mrs Gregory's medical condition around the times that breathlessness seemed a particular problem, e.g. 17th and 19th November 1999. If a thorough medical assessment of Mrs Gregory's breathlessness on the 17th November 1999 had considered it to be due to heart failure, then appropriate management of her heart failure could be seen as a more appropriate response to her episodes of breathlessness and anxiety rather than the use of morphine per se. On the 19th November 1999, a stat dose of frusemide 40mg was given IM at 15.45h because of breathlessness. In my experience, it is generally the case that a patient who is considered to be a degree of heart failure sufficient to

warrant parenteral frusemide, also warrants a medical review. Given this occurred at 15.45h, I would have considered it appropriate for Dr Barton/the doctor on call to have assessed Mrs Gregory as soon as was possible the same day, and not to have left until the following morning. Even so, there was no medical notes entry for 20th November 1999, although regular oral frusemide 40mg once a day was prescribed. I am not a cardiologist however, and the opinion of one could be sought if considered necessary regarding the above.

The use of a syringe driver with an anti-emetic was reasonable, given that Mrs Gregory was experiencing nausea and vomiting, and this is an indication for its use. The appropriateness of the use of diamorphine depends on the indication for the oral morphine.

However, the above issues aside, Mrs Gregory's decline was noted over a number of weeks and this would be in keeping with a natural decline into a terminal phase. Further, whatever the reason was for the use of diamorphine, the physical findings on the day of Mrs Gregory's death would suggest that the dose she was receiving was unlikely to have been excessive to the degree that it rendered her unresponsive or was associated with respiratory depression.

Form MG15(T)

RESTRICTED

RECORD OF INTERVIEW

Enter type: ROT
I
(SDN / ROTI / Contemporaneous Notes / Index of Interview with VIW / Visually recorded interview)

Person interviewed: BARTON, JANE ANN

Place of interview: NETLEY SUPPORT HEADQUARTERS

Date of interview: 25/08/2005

Time commenced: 0900 Time concluded: 0933

Duration of interview: 33 MINUTES (→) Tape reference nos. CSY/JAB/9

Interviewer(s): DC Code A YATES / DC Code A QUADE

Other persons present: MR BARKER, SOLICITOR

Police Exhibit No: CSY/JAB/9A Number of Pages: 26

Signature of interviewer producing exhibit

Person speaking	Text
DC YATES	This interview is being tape recorded. I am DC Code A Chris YATES. My colleague is …
DC QUADE	DC Code A Geoff QUADE.
DC YATES	… I'm interviewing Doctor Jane BARTON. Doctor will you please give your full name and your date of birth?
BARTON	Jane Ann BARTON, Code A

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DC YATES — Thank you. Also present is Mr BARKER, who is Doctor BARTON's solicitor. Can you please introduce yourself with your full name?

BARKER — Gladly my name is Ian Stephen Petrie BARKER and I confirm I am Doctor BARTON's solicitor.

DC YATES — Thank you. This interview is being conducted in an office within the Fraud Squad at Netley Support Headquarters in Hampshire. The time is nine o'clock, 0900 hours and the date is the 25th of August 2005. At the conclusion of the interview I'll give you a notice explaining what will happen to the tapes. I must remind you doctor that you're still entitled to free legal advice. Mr BARKER is here as your legal advisor. Have you had enough time to consult with Mr BARKER in private or would you like further time?

BARTON — Fine thank you.

DC YATES — If at any time you wish to stop the interview and take legal advice then just say so and we'll stop the interview and that can be done. I'd also like to point out that you have attended voluntarily, you're not under arrest and you've come here of your own free will. So if at any time that you wish to leave you're free to do so. I'll also caution you, you do not have to say anything but it may harm your defence if you do not mention when questioned something which you later rely on in court. Anything you do say maybe given in evidence. Do you understand that caution?

BARTON — I do.

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DC YATES — I usually ask you to explain it for my own peace of mind but end up explaining it myself, which I will do. I'll split it into the three normal parts, the first part is you haven't got to speak to us which you know. The last part is it can be given in evidence, it's being tape recorded. It's the middle bit, if you do not mention when questioned something which you later rely on in court. If you're asked questions and you do not mention something now and later should this go to court and give an answer then the court may and it is a may, take an inference. It's a very brief synopsis of it. On this occasion the room is not remotely monitored otherwise there would be a little red light on the machine. As before it'll be me speaking to you the majority of the time but DC QUADE will almost certainly be taking some notes during the interview. Mr BARKER the last time we met, hope I get it right this time, was Thursday 14th of July.

BARKER — You're right.

DC YATES — Thank you and we handed you by way of advanced disclosure for this interview copies of the medical notes of Enid SPURGEON and a brief synopsis of her care, is that right?

BARKER — Sheila GREGORY?

DC YATES — Sheila GREGORY. My fault.

DC YATES — No it's alright we've got Sheila GREGORY with us, Sheila GREGORY sorry had to get something wrong in there.

BARKER It's not a problem.

DC YATES Right are you happy with the disclosure we've given you anyway?

BARKER I'm happy that you've given me, ...

DC YATES Can you confirm ...

BARKER ... I can confirm that you've given me the medical records in relation to Sheila GREGORY as I am saying they are, yeah.

DC YATES ... yeah. Right this investigation is being conducted by the Hampshire Constabulary and it started in September 2002 and by now it's already been running nearly three years and still going to continue to run for a little bit more yet. It's an investigation into allegations of the unlawful killing of a number of patients at the Gosport War Memorial Hospital between 1990 and 2000. Now no decision has been made as to whether an offence or any offence has been committed but it's important to be aware that the offence range being investigated runs from potential murder right the way down to assault. Part of the ongoing enquiries is to interview witnesses who were involved in the care and treatment of the patients during that period. You were a clinical assistant, doctor, at the Gosport War Memorial Hospital at the time of these deaths so your knowledge of the working of the hospital, the care and the treatment of the patients is very central to our enquiry. The interview

today will concentrate on the care and treatment of Sheila GREGORY, who was admitted to Gosport War Memorial Hospital. Perhaps doctor in your own words you could tell me what you recollect of Mrs GREGORY's care and treatment that she received whilst at the Gosport War Memorial Hospital. Now the normal set up here is that you've got a prepared statement is that what's going to happen?

BARKER That's precisely correct.

DC YATES Okay. I'll ask you to read it in a second doctor. Can I just confirm that it's your statement and you made it?

BARTON My statement and I made it.

DC YATES Lovely, well if you'd like to read the statement doctor.

BARTON 'I am Dr Jane BARTON of the Forton Medical Centre, White's Place, Gosport, Hampshire . As you are aware, I am a General Practitioner and from 1988 until 2000, I was in addition the sole Clinical Assistant at the Gosport War Memorial Hospital.

I understand you are concerned to interview me in relation to a patient at the Gosport War Memorial Hospital, Mrs Sheila GREGORY. Unfortunately at this remove of time I have no recollection at all of Mrs GREGORY. As you are aware, I provided you with a statement on the 4th November 2004, which gave information about my practice generally, both in relation to my role as a General

Practitioner and as the clinical assistant at the Gosport War Memorial. I adopt that statement now in relation to general issues insofar as they relate to Mrs GREGORY.

In that statement I indicated when I had first taken up the post, the level of dependency of patients was relatively low and that in general the patients did not have major medical needs. I said that over time that position changed very considerably and that patients who were increasingly dependent would be admitted to the wards. I indicated that certainly by 1998 many of the patients were profoundly dependent with minimal Barthel scores and there was significant bed occupancy. The demands on my time and that of the nursing staff were considerable. I was in effect left with the choice of attending to my patients and making notes as best I could, or making more detailed notes about those I did see, but potentially neglecting other patients. The statement largely represented the position at the War Memorial Hospital in 1998. I confirm that these comments are indeed a fair and accurate summary of the position then though if anything it had become even more difficult by 1999 when I was involved in the care of Mrs GREGORY.

Mrs Sheila GREGORY was 91 years of age and lived alone in warden controlled accommodation. It appears that she was independent although had problems with mobility. She was supported by her extended family.

Her past medical history included emphysema (chronic obstructive pulmonary disease), hypothyroidism, ischaemic heart disease and atrial fibrillation. In 1995 she was seen

by Consultant Geriatrician Dr Althea LORD at the Queen Alexandra Hospital who found that Mrs GREGORY's main problems at that stage were hypertension, slow atrial fibrillation, mitral regurgitation and possible pulmonary congestion. A chest x-ray in February 1995 revealed that her heart was enlarged. ECG confirmed very slow atrial fibrillation with some lateral ischaemia.

In December 1998 Mrs GREGORY was admitted to the Royal Hospital Haslar suffering with breathlessness for 2 days. When seen by the clinicians at the hospital she was apparently unresponsive and was felt to be having an acute respiratory arrest. The overall impression was apparently of an acute type 2 respiratory failure with some underlying left ventricular failure. A chest x-ray carried out at that time confirmed the enlargement of the heart and it was felt the features were consistent with heart failure. Following discharge Mrs GREGORY was reviewed again at the Royal Hospital Haslar in February 1999 and at that time, although she had had occasional attacks of breathlessness for which she had been taking Salbutamol and Atrovent, it was felt that there was no evidence of left ventricular failure, although she had a loud murmur of mitral regurgitation.

On the 15th August 1999 Mrs GREGORY was admitted once more to the Royal Hospital Haslar following a fall. She was diagnosed as having a closed fracture of the proximal femur and at operation the following day a dynamic hip screw was inserted. The anaesthetist

conducting anaesthesia for the procedure assessed her in advance of the procedure as being ASA IV, being a high anaesthetic risk, commenting that she had very poor respiratory and cardio-vascular system reserve.

Mrs GREGORY's post operative recovery appears to have been relatively uncomplicated. On the 23rd August Dr LORD was asked to see her with a view to considering rehabilitation. In fact, it was Consultant Geriatrician, Dr Jane TANDY, who then saw her on the 23rd August. In her subsequent letter of the 24th August to Consultant Orthopaedic Surgeon Mr MIZRA, Dr TANDY observed that she had a past medical history of hypothyroidism, asthma and cardiac failure. At the time of the assessment she had an acute on chronic confusional state. Dr TANDY noted that Mrs GREGORY had previously lived alone in a warden controlled flat with family to help out. Apparently she was normally a bit confused but managed to get out to the shops. Her confusion had increased after the operation, particularly at night. She was now often quite confused and needed to be orientated in time and place. Dr TANDY noted a previous medical history of myxoedema, asthma and cardiac failure. She had been suffering from diarrhoea and had had a fever the previous day but she was beginning to mobilise and take a few steps with one nurse using a Zimmer frame. Dr TANDY said she would be happy to take Mrs GREGORY to the Gosport War Memorial Hospital. In her note of her assessment the previous day, Dr TANDY has also recorded:- "? will get home?", from which it would seem that whilst Dr TANDY felt that even if Mrs GREGORY did recover, she was not anticipating

complete rehabilitation and mobilisation to her previous state, and that she might have to go into residential care.

In any event Mrs GREGORY was then transferred to the Gosport War Memorial Hospital on the 3rd September 1999. The referral letter from the Royal Hospital Haslar confirmed the previous history of left ventricular failure, hypertension, asthma and hypothyroidism. The medication she was then taking was also itemised.

I admitted Mrs GREGORY to Dryad Ward at the GWMH on 3rd September in Mrs GREGORY's records in this regard reads as follows:-

"3-9-99 Transfer to Dryad Ward continuing care
HPC # no femur ® 16-8-99
PMH hypothyroidism
Asthma
Cardiac failure
Barthel needs help c ADL
Incontinent
Transfers with 2 Barthel 3-4
Plan Get to know
Gentle rehab
? nursing home
please make comfortable
I am happy for nursing staff to confirm death'.

As it is clear from my note, I assessed Mrs GREGORY's Barthel score as 3-4, though two days later a nursing assessment has it recorded as 2. It was apparent though

that Mrs GREGORY was significantly dependent at that time. In accordance with my usual practice, I recorded that I was happy for nursing staff to confirm death. As I have previously indicated, this was simply to ensure that nursing staff were aware that it was not necessary for a doctor to be called out of hours if the patient were to die and a doctor was not available at the hospital at the time. From my assessment, I hoped that rehabilitation might indeed prove possible but at the same time, recognising that Mrs GREGORY had had the trauma of a fracture, followed by operation and then a move to another hospital, and in circumstances in which she had a number of medical problems, there was the clear possibility for deterioration in her condition.

I prescribed medication for Mrs GREGORY in the form of Co-dydramol and Oramorph for pain relief, the Oramorph at a dose of 2.5 to 5mls in a 10mg 5mls solution 4 hourly. Prochloperazine as an anti-emetic, and Zopiclone to help her sleep, all to be available as required. I also prescribed Thyroxine 100mcgs once a day for hypothyroidism, Ferrous Sulphate 200mgs 3 times a day for iron deficiency anaemia, Lactulose 15mls twice a day and 2 senna tablets at night both for constipation, and Atrovent and Becloforte inhalers for her chronic obstructive pulmonary disease.

In addition, I also prescribed Diamorphine 20-200mgs, Hyoscine 200-800mcgs and Midazolam 20-80mgs to be available via syringe driver if necessary. In doing so, I did not consider that it was necessary for these medications including Diamorphine to be administered at that point and

would not have approved the administration if I had been asked to do so. Rather, I was concerned that if there were to be a deterioration, such medication could then be available as necessary. If I was not immediately available in the hospital, I would nonetheless be consulted by the nursing staff before it was commenced.

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clinical care work at Gosport War Memorial Hospital as best I can recall it.

Unfortunately, although Dr REID's weekly attendance for a ward round on Dryad Ward was welcome, Dr REID, in addition to agreeing to a transfer of patients for other hospitals, would also agree to take admissions from home. Patients admitted from home had not had the same degree of thorough investigation and stabilisation prior to admission, and this increased the workload still further.

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The nursing record on the 6th September confirms that she was seen by Dr RAVI complaining and complained of a painful right thumb, with Dr RAVI suspecting a Scaphoid fracture, although it appears the x-ray was reported as normal.

From Dr RAVI's note it appears that there was a suspicion that Mrs GREGORY might have had a cerebro-vascular accident or thrombotic stroke, particularly in the presence of atrial fibrillation, but in fact none of the hard neurological signs were present which would have demonstrated the diagnosis.

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Mrs GREGORY was seen again the following week, on the 13th September by Dr Ian REID in the course of what would have been his weekly ward round. He noted that she was leaning to the left while standing, had a poor appetite, was confused but witty. He felt that she had a poor inhaler technique and that she should try nebulisers. He therefore changed the prescription for inhalers to nebulisers, specifically Ipritropin and Budesonide nebulisers.

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Three days later on the 23rd September Mrs GREGORY was apparently found on the floor next to her bed, with no apparent injuries. Cot sides were put in place.

Mrs GREGORY was seen once more by Dr REID on his weekly ward round on the 27th September and on this occasion he noted that her appetite had slightly improved, as had her mood and he recorded that the Fluoxetine should continue. However, he noted that she was generally less well although there were no obvious physical signs.

On the 1st October Mrs GREGORY was apparently found on the floor twice in the course of the night, and I think in consequence of that I then prescribed Thioridazine on 1st October, to relieve agitation.

Dr REID reviewed Mrs GREGORY again on the 4th October, noting that she had much better motivation. She needed the help of one person and occasionally two for most activities. He recorded that she needed Thioridazine for occasional agitation and still needed encouragement to eat and drink.

It appears that restlessness and agitation at night was a feature of Mrs GREGORY's condition, it being noted that she required sedation to help her sleep.

It seems the Thioridazine was effective, subsequent entries in the night nursing record following 1st October recording that Thioridazine was generally given with good effect.

On 7th October Sister HAMBLIN recorded that Mrs GREGORY was generally unwell, complaining of acute pain in the top of her head and the side of her face and was feeling nauseated.

I wrote up a further drug chart for Mrs GREGORY the same day, prescribing Thyroxine, Lactulose, Senna tablets, Fluoxetine Elixir, Aspirin, Paracetamol, Thioridazine and Temazepam, the last being available to assist with sleeping if the Thioridazine was unsuccessful in relieving Mrs GREGORY's restlessness at night. The Diamorphine, Hyoscine and Midazolam continued to be available, in the event of deterioration.

The nursing records indicate that on 8th October Mrs GREGORY continued to feel nauseous at times with a small amount of diet being taken. Accordingly, I prescribed Gaviscon to be available as required, although the drug chart appears to indicate that it was not necessary to administer Gaviscon until 23rd October. I also wrote up Oramorph to be available, as indeed it had been previously, at 2.5 to 5mls in a 10mg/5mls solution 4 hourly.

Dr REID saw Mrs GREGORY again on his ward round on the 11th October, recording that she was still very depressed, was dehydrating visibly and was confused. He said that she needed a nursing home placement, apparently of the view that if she could be rehabilitated, she would be unable to live at home.

It appears that the same day I asked that Metoclopramide be prescribed, Sister HAMBLIN noting this on the prescription chart as being a verbal request by me, which I then subsequently endorsed with my signature. I anticipate that Mrs GREGORY had experienced nausea or vomiting and I would have been concerned that medication should be available for her if there was any recurrence.

On his next weekly ward round, on 18th October, Dr REID noted that Mrs GREGORY had unformed faeces and he instructed that lactulose should be withheld for the time being. He again noted that she was to be referred for nursing home care. The prescription chart shows that on the same day, and I anticipate in view of the finding noted by Dr REID, I prescribed Loperamide.

On 22nd October it was noted on the nursing care plan that Mrs GREGORY had a poor appetite and might be prone to becoming malnourished. The aim was to ensure that she had adequate nutritional intake.

Dr REID saw Mrs GREGORY once more, on 25th October when he recorded that she could walk with a frame and with significant persuasion. She needed one to two people

to assist her in transferring and dressing. She remained catheterised.

On 27th October Sister HAMBLIN recorded on the drug chart that my partner, Dr BEASLEY, had signed out a prescription for Magnesium Hydroxide, 20mls twice a day, apparently on a verbal request from me. I anticipate that I would have been concerned about the possibility of constipation as I think Lactulose had been discontinued about 2 weeks earlier.

On 1st November Dr REID then recorded that Mrs GREGORY had had an episode of vomiting that day but seemed well when he saw her. He recorded that she still had soft mushy stools and that the Magnesium Hydroxide should be reduced to 10mls twice a day.

Accordingly, I wrote a prescription to that effect, in substitution for the one I had written on 27th October.

I also prescribed an antibiotic Cefaclor, the same day, 1st November, though this does not appear to have been administered and I am unable now to say why.

There is no entry in the clinical records by Dr REID for 8th November, and I cannot now say if he would have seen Mrs GREGORY on this occasion. I anticipate that her condition was essentially unchanged at this time.

It appears that on 11th November I wrote up a further 'as required' prescription for Diamorphine, Hyoscine,

Midazolam and Cyclizine at the previously stated dose ranges, to be available by syringe driver. Again, it was not my expectation that it was immediately necessary to administer that medication but I would have been concerned as previously, that Mrs GREGORY's condition might deteriorate and the medication should be available if necessary. Clearly Dr REID would have reviewed the prescription chart when conducting his weekly ward rounds and would have been aware of the fact that I had consistently written up these drugs to be available if necessary. At no time did Dr REID indicate any concern that these drugs had been written up to be available on this basis and within these dose ranges, either in relation to Mrs GREGORY or indeed for any other patient for whom I considered it necessary to prescribe such medication.

As I have indicated above, I believe that I would have reviewed Mrs GREGORY day by day each weekday, though there may of course have been days when I was unable to attend at the hospital. However, I was abroad on leave from 12th November until 16th November and would not have seen Mrs GREGORY again until my return.

In my absence, Dr REID saw Mrs GREGORY again on 15th November when he recorded that she was less well, had a chest infection and was frailer. He noted occasional bouts of nausea. On examination she had no raised temperature, her pulse rate was 84 beats per minute and regular. She had loud heart sounds with the third sound radiating into the axilla and neck. There was no oedema,

and Dr REID felt that her treatment should continue save for a change to Thioridazine – to be available as required.

Unfortunately, it appears that Mrs GREGORY continued to deteriorate. A nursing entry on the 17th November records that she was not very well that evening, becoming quite distressed and breathless at times. In view of this, it was felt appropriate to administer 5mgs of Oramorph at 10pm (2200) in order to relieve distress, and the nursing record indicates this had good effect.

The following day, 18th November Mrs GREGORY was noted to be still unwell, feeling quite anxious and the nurses have recorded that after discussion with me it was felt that Oramorph at 5mgs to be given on a regular basis – 4 hourly would be of benefit. 5mgs was then given at 1030am, 2.35pm (1435) and 6.30pm (1830) that day.

I also made a specific entry in Mrs GREGORY's notes on 18th November, recording as follows:-

'18-11-99 Further deterioration in general condition
Start oral opiates in a small does
Please make comfortable
I will speak to granddaughter
I am happy for nursing staff to confirm death
? further C.V.A.?'

Clearly in view of my note I was concerned that Mrs GREGORY might have had another cerebro-vascular

accident, perhaps accounting for the further deterioration in her condition. My note confirms that I agreed with the nursing staff that a small amount of Oramorph should be available in order to make Mrs GREGORY comfortable. I believe that I was concerned now that Mrs GREGORY was deteriorating and that she might well now die. I would have been anxious in those circumstances to speak with Mrs GREGORY's granddaughter to warn her that this might be the case. I wrote up a further prescription chart the same day for Thyroxine, Fluoxetine Elixir, Magnesium Hydroxide and Oramorph. In addition to the 2.5mls of Oramorph 4 times a day, I also recorded that a further 5mls should be available at night and accordingly a further 5mls appears to have been given at 10pm (2200).

In addition I also wrote up a further 'as required' prescription on the 18th November for the Diamorphine, Hyoscine, Midazolam and Cyclizine at the previously stated doses.

The following day, 19th November the nurses recorded that Mrs GREGORY was poorly but stable in the morning. She then complained of shortness of breath in the afternoon. I think I was informed of this by the nursing staff and in consequence of that asked that Frusemide should be given – 40mgs intra-muscularly in order to reduce what I probably felt was pulmonary oedema. I think I was concerned that Mrs GREGORY was likely to be developing congestive cardiac failure. In those circumstances the administration of Oramorph would also

have assisted in relieving her shortness of breath and indeed the anxiety and distress produced from this.

The nursing record indicates that 5mls of Oramorph was administered prior to Mrs GREGORY settling and that she then slept for long periods. It appears therefore that she had a peaceful night, and that the Oramorph might well have been successful in relieving the distress of her condition.

Unfortunately, the following day – 20th November some deterioration was noted by the nursing staff and Mrs GREGORY's granddaughter was advised to visit her that morning. Mrs GREGORY apparently vomited and Cyclizine was given, apparently with good effect.

In view of Mrs GREGORY's continuing deterioration, I felt that it was appropriate to change from repeated administrations of Oramorph to the administration of Diamorphine via the syringe driver. On the 18th November Mrs GREGORY had received 25mgs of Oramorph and a further 30mgs the following day. Diamorphine was commenced at 20mgs representing a relatively moderate increase from the level of opiates from the Oramorph previously provided. 50mgs of Cyclizine was also administered via the syringe driver, that having previously been given intra-muscularly with good effect.

Mrs GREGORY was then said to have had a comfortable night and the syringe driver was apparently satisfactory.

The nursing record indicates that on the afternoon of the 21st November Mrs GREGORY's condition remained poorly and that all care continued.

Dr REID then reviewed Mrs GREGORY once more on his weekly ward round on 22nd November. His note indicates that there had been a further deterioration. He recorded that Mrs GREGORY was comfortable, opening her eyes to speech and with short verbal responses. Her pulse was uncontrolled with atrial fibrillation and her respiratory rate was 24 breaths per minute. Her chest was clear at that time. He indicated that the Frusemide should be stopped, but specifically recorded that the Diamorphine should continue.

Clearly from this note it is apparent that Dr REID felt able to modify medication which I had prescribed, specifically stopping the Frusemide. I anticipate that he would have felt by this stage that Mrs GREGORY was dying and that the Frusemide administered orally would not be of any significant benefit. Clearly, however, he was content that the Diamorphine which I had instituted should be continued.

Dr REID's note that Mrs GREGORY's pulse was uncontrolled and that there was atrial fibrillation would suggest to me that Mrs GREGORY was experiencing heart failure and was dying.

I anticipate that I would have seen Mrs GREGORY the same day and the nursing staff would also have attended to

see her, though neither the nursing staff nor I had the opportunity to make a note in addition to Dr REID's record. Sadly it appears that Mrs GREGORY died peacefully at about 5.20pm (1720) on the afternoon of 22nd November.

The Diamorphine and indeed the Oramorph which preceded it, was prescribed by me and in my view administered solely with the intention of relieving the shortness of breath Mrs GREGORY was experiencing from what I believed to be her cardiac failure and the anxiety and distress which Mrs GREGORY was suffering in consequence. At no time was the medication provided with the intention of hastening Mrs GREGORY's demise'.

DC YATES — Thank you very much. I think, certainly at paragraph 12 was it ...

BARKER — Yes can I also draw a couple of points to Dr BARTON's attention ...

DC YATES — ... yes.

BARKER — ... help? First off at paragraph ten in fact I think there might be a couple of words missing, 'I admitted Mrs GREGORY to Dryad Ward at the Gosport War Memorial Hospital on 3rd of September' and I think it should perhaps say 'and my note' after the word September. Does that make sense?

RESTRICTED

DC YATES Yeah. sorry as you add these in Doctor can I just get you to ...

BARTON Initial them?

DC YATES ... initial them, yeah it will save doing them later.

BARTON And there's the mistake with the Ferrous Sulphate dosage it's 200.

BARKER You said 200.

DC YATES Yeah.

BARKER That's it.

DC YATES So is it 200 or is it 20?

BARTON 200.

DC YATES It is 200.

BARKER And just to be clear at paragraph 18, four lines up from the bottom there where it says 'tenderness in the right ...' and you added the word anatomical ...

BARTON Anatomical snuff box, sounds as if she was carrying tobacco on her person otherwise.

BARKER ... I think those are the only additions which are of significance, yes.

RESTRICTED

DC YATES — Can I ask, I normally ask you Doctor if your'e happy with that statement to sign it at the end.

BARTON — It's also for Lactulose is fifteen mils not milligrams.

BARKER — Oh and that's paragraph twelve?

BARTON — It's only in paragraph twelve, yes. So you'd like signed ...

DC YATES — And handed to DC YATES.

BARKER — Lovely.

DC YATES — I think for the purpose of the tape I'll give this prepared statement an identification reference of JB/PS/8, thank you. I intend to call a stop to the interview at the moment. It's just where we (inaudible) the time in order that we can consider the information that you've provided in this statement. I may well wish to put a number of questions to you later about, this statement but would you be prepared to answer any questions if I did?

BARTON — No.

DC YATES — No.

BARKER — Can I say that Doctor BARTON is answering that on the basis of advice that I've tended to her previously and I won't rehearse them all over again the reasons for that but

the same reasons that I've articulated previously apply and I know you understand.

DC YATES — That's not a problem at all. Is there anything that you wish to clarify? Anything you wish to add?

BARTON — No thank you.

DC YATES — Got a notice here explains the tape recording procedure and what will happen to the tapes. The time is 0933 hours and I'm turning the recorder off.

Copy JB/PS/1

STATEMENT OF DR JANE BARTON

RE: SHEILA GREGORY

1. I am Dr Jane Barton of the Forton Medical Centre, White's Place, Gosport, Hampshire. As you are aware, I am a General Practitioner, and from 1988 until 2000, I was in addition the sole clinical assistant at the Gosport War Memorial Hospital (GWMH).

2. I understand you are concerned to interview me in relation to a patient at the GWMH, Mrs Sheila Gregory. Unfortunately, at this remove of time I have no recollection at all of Mrs Gregory. As you are aware, I provided you with a statement on the 4th November 2004, which gave information about my practice generally, both in relation to my role as a General Practitioner and as the clinical assistant at the GWMH. I adopt that statement now in relation to general issues insofar as they relate to Mrs Gregory.

3. In that statement I indicated when I had first taken up the post, the level of dependency of patients was relatively low and that in general the patients did not have major medical needs. I said that over time that position changed very considerably and that patients who were increasingly dependent would be admitted to the wards. I indicated that certainly by 1998 many of the patients were profoundly dependent with minimal Barthel scores, and there was significant bed occupancy. The demands on my time and that of the nursing staff were considerable. I was in effect left with the choice of attending to my patients and making notes as best I could, or making more detailed notes about those I did see, but potentially neglecting other patients.

The statement largely represented the position at the GWMH in 1998. I confirm that these comments are indeed a fair and accurate summary of the position then, though if anything, it had become even more difficult by 1999 when I was involved in the care of Mrs Gregory.

4. Mrs Sheila Gregory was 91 years of age and lived alone in warden controlled accommodation. It appears that she was independent although had problems with mobility. She was supported by her extended family.

5. Her past medical history included emphysema (chronic obstructive pulmonary disease), hypothyroidism, ischaemic heart disease, and atrial fibrillation. In 1995 she was seen by Consultant Geriatrician Dr Althea Lord at the Queen Alexandra Hospital who found that Mrs Gregory's main problems at that stage were hypertension, slow atrial fibrillation, mitral regurgitation and possible pulmonary congestion. A chest x-ray in February 1995 revealed that her heart was enlarged. ECG confirmed very slow atrial fibrillation with some lateral ischaemia.

6. In December 1998 Mrs Gregory was admitted to the Royal Hospital, Haslar suffering with breathlessness for 2 days. When seen by the Clinicians at the hospital she was apparently unresponsive and was felt to be having an acute respiratory arrest. The overall impression was apparently of an acute type 2 respiratory failure with some underlying left ventricular failure. A chest x-ray carried out at that time confirmed the enlargement of the heart and it was felt the features were consistent with heart failure. Following discharge Mrs Gregory was reviewed again at the Royal Hospital Haslar in February 1999, and at that time, although she had had occasional attacks of breathlessness for which she had been taking Salbutamol and Atrovent, it was felt that

there was no evidence of left ventricular failure, although she had a loud murmur of mitral regurgitation.

7. On the 15th August 1999 Mrs Gregory was admitted once more to the Royal Hospital Haslar following a fall. She was diagnosed as having a closed fracture of the proximal femur, and at operation the following day a dynamic hip screw was inserted. The Anaesthetist conducting anaesthesia for the procedure assessed her in advance of the procedure as being ASA IV, being a high anaesthetic risk, commenting that she had very poor respiratory and cardio-vascular system reserve.

8. Mrs Gregory's post-operative recovery appears to have been relatively uncomplicated. On the 23rd August Dr Lord was asked to see her with a view to considering rehabilitation. In fact, it was Consultant Geriatrician, Dr Jane Tandy, who then saw her on the 23rd August. In her subsequent letter of the 24th August to Consultant Orthopaedic Surgeon Mr Mizra, Dr Tandy observed that she had a past medical history of hypothyroidism, asthma and cardiac failure. At the time of the assessment she had an acute on chronic confusional state. Dr Tandy noted that Mrs Gregory had previously lived alone in a warden controlled flat with family to help out. Apparently she was normally a bit confused but managed to get out to the shops. Her confusion had increased after the operation, particularly at night. She was now often quite confused and needed to be orientated in time and place. Dr Tandy noted a previous medical history of myxoedema, asthma and cardiac failure. She had been suffering from diarrhoea and had had a fever the previous day, but she was beginning to mobilise and take a few steps with one nurse using a Zimmer frame. Dr Tandy said she would be happy to take Mrs Gregory to the GWMH. In her note of her assessment the previous day, Dr Tandy has also recorded: - "? will get

home?", from which it would seem that whilst Dr Tandy felt that even if Mrs Gregory did recover, she was not anticipating complete rehabilitation and mobilisation to her previous state, and that she might have to go into residential care.

9. In any event Mrs Gregory was then transferred to the GWMH on the 3rd September 1999. The referral letter from the Royal Hospital Haslar confirmed the previous history of left ventricular failure, hypertension, asthma and hypothyroidism. The medication she was then taking was also itemised.

10. I admitted Mrs Gregory to Dryad Ward at the GWMH on 3rd September and my note in Mrs Gregory's records in this regard reads as follows:-

"3-9-99 Transfer to Dryad Ward continuing care
HPC # no femur ® 16-8-99
PMH hypothyroidism
asthma
cardiac failure
Barthel needs help c ADL
incontinent
transfers with 2 Barthel 3-4
Plan Get to know
Gentle rehab
? nursing home
please make comfortable
I am happy for nursing staff to confirm death"

11. As is clear from my note, I assessed Mrs Gregory's Barthel score as 3-4, though two days later a nursing assessment has recorded it as 2. It was apparent though that Mrs Gregory was significantly dependent at that time. In accordance with my usual practice, I recorded that I was happy for nursing staff to confirm death. As I have previously indicated, this was simply to ensure that nursing staff were aware that

it was not necessary for a doctor to be called out of hours if the patient were to die and a doctor was not available at the hospital at the time. From my assessment, I hoped that rehabilitation might indeed prove possible, but at the same time, recognising that Mrs Gregory had had the trauma of a fracture, followed by operation, and then a move to another hospital, and in circumstances in which she had a number of medical problems, there was the clear possibility for deterioration in her condition.

12. I prescribed medication for Mrs Gregory in the form of Co-dydramol and Oramorph for pain relief, the Oramorph at a dose of 2.5 to 5mls in a 10mg 5mls solution 4 hourly, Prochloperazine as an anti-emetic, and Zopiclone to help her sleep, all to be available as required. I also prescribed Thyroxine 100mcgs once a day for hypothyroidism, Ferrous Sulphate 200mgs 3 times a day for iron deficiency anaemia, Lactulose 15mls twice a day and 2 senna tablets at night both for constipation, and Atrovent and Becloforte inhalers for her chronic obstructive pulmonary disease.

13. In addition, I also prescribed Diamorphine 20-200mgs, Hyoscine 200-800mcgs, and Midazolam 20-80mgs to be available via syringe driver if necessary. In doing so, I did not consider that it was necessary for these medications including Diamorphine to be administered at that point, and would not have approved the administration if I had been asked to do so. Rather, I was concerned that if there were to be a deterioration, such medication could then be available if necessary. If I was not immediately available in the hospital, I would nonetheless be consulted by the nursing staff before it was commenced.

14. The nursing entry the same day - 3rd September recorded that Mrs Gregory could become confused at times and needed orientating in terms of time and space. She was noted to mobilise with the help of one nurse and using a Zimmer frame, and had an in-dwelling catheter and could be incontinent of faeces.

15. I anticipate that I would then have seen Mrs Gregory to review her condition day by day, each week day. Unfortunately, I was not able to make notes in my routine assessments of her, I anticipate due to the sheer pressure of work at the time and in circumstances in which the Consultant was in any event making a regular weekly note following ward round assessment. I would have endeavoured to make a note if Mrs Gregory's condition changed significantly.

16. By 1999 the Healthcare Trust had appointed a Clinical Director, Dr Ian Reid, and one of his responsibilities was for Dryad Ward. In consequence, unless he was unavailable, Dr Reid would carry out a weekly ward round. Dr Reid had effectively taken over responsibility for Dryad Ward from Dr Jane Tandy who, having returned from maternity leave, did not then carry out clinical care work at GWMH as best I can recall it.

17. Unfortunately, although Dr Reid's weekly attendance for a ward round on Dryad Ward was welcome, Dr Reid, in addition to agreeing to a transfer of patients for other hospitals, would also agree to take admissions from home. Patients admitted from home had not had the same degree of thorough investigation and stabilisation prior to admission, and this increased the workload still further.

18. In any event on the 6th September Mrs Gregory was seen by a locum Consultant Dr Ravi who recorded that she was noticed to have left sided facial droop, but was now better. There was apparently no visual disturbance, no facial weakness nor arm weakness and both plantars were down. He considered that Mrs Gregory was in atrial fibrillation and had a small pressure sore. She was said to be 'in retention', by which I anticipate he meant that she was retaining urine. He noted pain and tenderness in the right anatomical snuff box - Code A on her wrist/hand. Dr Ravi prescribed Aspirin for the atrial fibrillation, asked for an x-ray of the right hand, clearly suspecting a scaphoid fracture, and indicated that she should mobilise.

19. The nursing record on the 6th September confirms that she was seen by Dr Ravi complaining, and complained of a painful right thumb, with Dr Ravi suspecting a Scaphoid fracture, though it appears the x-ray was reported as normal.

20. From Dr Ravi's note it appears that there was a suspicion that Mrs Gregory might have had a cerebro-vascular accident or thrombotic stroke, particularly in the presence of atrial fibrillation, but in fact none of the hard neurological signs were present which would have demonstrated the diagnosis.

21. In addition to the Aspirin Dr Ravi also prescribed Fluoxetine, which was commenced the following day. The prescription for Fluoxetine was actually written out by me, and no doubt I would have done this on Dr Ravi's request. This would have been provided for depression.

22. It appears that the same day I also prescribed Paracetamol Ellixir 1gm 4 times a day to be available to Mrs Gregory to relieve pain.

23. Mrs Gregory was seen again the following week, on the 13th September by Dr Ian Reid in the course of what would have been his weekly ward round. He noted that she was leaning to the left while standing, had a poor appetite, was confused but witty. He felt that she had a poor inhaler technique and that she should try nebulisers. He therefore changed the prescription for inhalers to nebulisers, specifically Ipritropin and Budesonide nebulisers.

24. I prescribed Daktacort cream the same day for what I anticipate was a fungal infection on the skin.

25. Mrs Gregory was reviewed again by Dr Reid the following week on his ward round, on 20th September. His note on this occasion indicated that she was managing nebulisers but had a very poor appetite. There was variable confusion, and she was able to mobilise one to two steps with the help of two people. Dr Reid asked that routine blood tests should be undertaken, and there is a corresponding entry in the nursing records to that effect.

26. Three days later on the 23rd September Mrs Gregory was apparently found on the floor next to her bed, with no apparent injuries. Cot sides were put in place.

27. Mrs Gregory was seen once more by Dr Reid on his weekly ward round on the 27th September, and on this occasion he noted that her appetite had slightly improved, as had her mood, and he recorded that the Fluoxetine should continue. However, he noted that she was generally less well although there were no obvious physical signs.

28. On the 1st October Mrs Gregory was apparently found on the floor twice in the course of the night, and I think in consequence of that I then prescribed Thioridazine on 1st October, to relieve agitation.

29. Dr Reid reviewed Mrs Gregory again on the 4th October, noting that she had much better motivation. She needed the help of one person and occasionally two for most activities. He recorded that she needed Thioridazine for occasional agitation and still needed encouragement to eat and drink.

30. It appears that restlessness and agitation at night was a feature of Mrs Gregory's condition, it being noted that she required sedation to help her sleep.

31. It seems the Thioridazine was effective, subsequent entries in the night nursing record following 1st October recording that Thioridazine was given generally with good effect.

32. On 7th October Sister Hamblin recorded that Mrs Gregory was generally unwell, complaining of acute pain in the top of her head and the side of her face, and was feeling nauseated.

33. I wrote up a further drug chart for Mrs Gregory the same day, prescribing Thyroxine, Lactulose, Senna tablets, Fluoxetine Elixir, Aspirin, Paracetamol, Thioridazine and Temazepam, the latter being available to assist with sleeping if the Thioridazine was unsuccessful in relieving Mrs Gregory's restlessness at night. The Diamorphine, Hyoscine and Midazolam continued to be available, in the event of deterioration.

34. The nursing records indicate that on 8th October Mrs Gregory continued to feel nauseous at times with a small amount of diet being taken. Accordingly, I prescribed Gaviscon to be available as required, although the drug chart appears to indicate that it was not necessary to administer Gaviscon until 23rd October. I also wrote up Oramorph to be available, as indeed it had been previously, at 2.5 to 5mls in a 10mg/5mls solution 4 hourly.

35. Dr Reid saw Mrs Gregory again on his ward round on the 11th October, recording that she was still very depressed, was dehydrating visibly and was confused. He said that she needed a nursing home placement, apparently of the view that if she could be rehabilitated, she would be unable to live at home.

36. It appears that the same day I asked that Metoclopramide be prescribed, Sister Hamblin noting this on the prescription chart as being a verbal request by me, which I then subsequently endorsed with my signature. I anticipate that Mrs Gregory had experienced nausea or vomiting, and I would have been concerned that medication should be available for her if there was any recurrence.

37. On his next weekly ward round, on 18th October, Dr Reid noted that Mrs Gregory had unformed faeces and he instructed that lactulose should be withheld for the time being. He again noted that she was to be referred for nursing home care. The prescription chart shows that on the same day, and I anticipate in view of the finding noted by Dr Reid, I prescribed Loperamide.

38. On 22nd October it was noted on the nursing care plan that Mrs Gregory had a poor appetite and might be prone to becoming malnourished. The aim was to ensure that she had adequate nutritional intake.

39. Dr Reid saw Mrs Gregory once more, on 25th October when he recorded that she could walk with a frame and with significant persuasion. She needed one to two people to assist her in transferring and dressing. She remained catheterised.

40. On 27th October Sister Hamblin recorded on the drug chart that my partner Dr Beasley had signed out a prescription for Magnesium Hydroxide, 20mls twice a day, apparently on a verbal request from me. I anticipate that I would have been concerned about the possibility of constipation as I think Lactulose had been discontinued about 2 weeks earlier.

41. On 1st November Dr Reid then recorded that Mrs Gregory had had an episode of vomiting that day but seemed well when he saw her. He recoded that she still had soft mushy stools, and that the Magnesium Hydroxide should be reduced to 10mls twice a day.

42. Accordingly, I wrote a prescription to that effect, in substitution for the one I had written on 27th October.

43. I also prescribed an antibiotic Cefaclor, the same day, 1st November, though this does not appear to have been administered, and I am unable now say why.

44. There is no entry in the clinical records by Dr Reid for 8th November, and I cannot now say if he would have seen Mrs Gregory on this

occasion. I anticipate that her condition was essentially unchanged at this time.

45. It appears that on 11th November I wrote up a further 'as required' prescription for Diamorphine, Hyoscine, Midazolam and Cyclizine at the previously stated dose ranges, to be available by syringe driver. Again, it was not my expectation that it was immediately necessary to administer that medication, but I would have been concerned as previously, that Mrs Gregory's condition might deteriorate and the medication should be available if necessary. Clearly Dr Reid would have reviewed the prescription chart when conducting his weekly ward rounds, and would have been aware of the fact that I had consistently written up these drugs to be available if necessary. At no time did Dr Reid indicate any concern that these drugs had been written up to be available on this basis and within these dose ranges, either in relation to Mrs Gregory or indeed for any other patient for whom I considered it necessary to prescribe such medication.

46. As I have indicated above, I believe that I would have reviewed Mrs Gregory day by day each weekday, though there may of course have been days when I was unable to attend at the hospital. However, I was abroad on leave from 12th November until 16th November, and would not have seen Mrs Gregory again until my return.

47. I my absence, Dr Reid saw Mrs Gregory again on 15th November when he recorded that she was less well, had a chest infection and was frailer. He noted occasional bouts of nausea. On examination she had no raised temperature, her pulse rate was 84bpm and regular. She had loud heart sounds with the third sound radiating into the axilla and neck. There

was no oedema, and Dr Reid felt that her treatment should continue save for a change to Thioridazine - to be available as required.

48. Unfortunately, it appears that Mrs Gregory continued to deteriorate. A nursing entry on the 17th November records that she was not very well that evening, becoming quite distressed and breathless at times. In view of this, it was felt appropriate to administer 5mgs of Oramorph at 10pm in order to relieve distress, and the nursing record indicates this had good effect.

49. The following day, 18th November Mrs Gregory was noted to be still unwell, feeling quite anxious and the nurses have recorded that after discussion with me it was felt that Oramorph at 5mgs to be given on a regular basis - 4 hourly would be of benefit. 5mgs was then given at 10.30am, 2.35pm and 6.30pm that day.

50. I also made a specific entry in Mrs Gregory's notes on 18th November, recording as follows:-

> "18-11-99 Further deterioration in general condition
> Start oral opiates in a small dose
> please make comfortable
> I will speak to granddaughter
> I am happy for nursing staff to confirm death
> ? further C.V.A. ?"

51. Clearly in view of my note I was concerned that Mrs Gregory might have had another cerebro-vascular accident, perhaps accounting for the further deterioration in her condition. My note confirms that I agreed with the nursing staff that a small amount of Oramorph should be available in order to make Mrs Gregory comfortable. I believe that I was concerned now that Mrs Gregory was deteriorating and that she

might well now die. I would have been anxious in those circumstances to speak with Mrs Gregory's granddaughter to warn her that this might be the case. I wrote up a further prescription chart the same day for Thyroxine, Fluoxetine Elixir, Magnesium Hydroxide and Oramorph. In addition to the 2.5mls of Oramorph 4 times a day, I also recorded that a further 5mls should be available at night, and accordingly a further 5mls appears to have been given at 10pm.

52. In addition I also wrote up a further 'as required' prescription on the 18th November for the Diamorphine, Hyoscine, Midazolam and Cyclizine at the previous stated doses.

53. The following day, 19th November the nurses recorded that Mrs Gregory was poorly but stable in the morning. She then complained of shortness of breath in the afternoon. I think I was informed of this by the nursing staff and in consequence of that asked that Frusemide should be given - 40mgs intra-muscularly in order to reduce what I probably felt was pulmonary oedema. I think I was concerned that Mrs Gregory was likely to be developing congestive cardiac failure. In those circumstances the administration of Oramorph would also have assisted in relieving her shortness of breath, and indeed the anxiety and distress produced from this.

54. The nursing record indicates that 5mls of Oramorph was administered prior to Mrs Gregory settling, and that she then slept for long periods. It appears therefore that she had a peaceful night, and the Oramorph might well have been successful in relieving the distress of her condition.

60. Clearly from this note it is apparent that Dr Reid felt able to modify medication which I had prescribed, specifically stopping the Frusemide. I anticipate that he would have felt by this stage that Mrs Gregory was dying, and the Frusemide administered orally would not be of any significant benefit. Clearly, however, he was content that the Diamorphine which I had instituted should be continued.

61. Dr Reid's note that Mrs Gregory's pulse was uncontrolled and that there was atrial fibrillation would suggest to me that Mrs Gregory was experiencing heart failure and was dying.

62. I anticipate that I would have seen Mrs Gregory the same day, and the nursing staff would also have attended to see her, though neither the nursing staff nor I had the opportunity to make a note in addition to Dr Reid's record. Sadly it appears that Mrs Gregory died peacefully at about 5.20pm on the afternoon of 22nd November.

63. The Diamorphine, and indeed the Oramorph which preceded it, was prescribed by me and in my view administered solely with the intention of relieving the shortness of breath Mrs Gregory was experiencing from what I believed to be her cardiac failure, and the anxiety and distress which Mrs Gregory was suffering in consequence. At no time was the medication provided with the intention of hastening Mrs Gregory's demise.

Signed and handed to DC Yates
25-2-03

Code A

MG 9

RESTRICTED – FOR POLICE, PROSECUTION, AND THE WITNESS SERVICE ONLY

URN:

WITNESS LIST

Date of completion:

✸ Tick if statement attached

◆ Previous convictions? Enter Y or N

R v

Wit No	Witness Details (In the 'Wit.No.' column enter 'V' if the witness is a victim, 'Vu' if vulnerable or intimidated)	Statement Number	✸	◆
1	Name: JANET ROSEMARY MARTIN-ROGERS Address (HOME): Code A Occupation: Code A Telephone: E-mail address: Date of Birth: Code A			
2	Name: PAULINE GREGORY Address (HOME): Code A Occupation: Telephone: Code A E-mail address: Date of Birth: Code A			
3	Name: DEAN LEE GREGORY Address (HOME): Code A Occupation: Code A Telephone: E-mail address: Date of Birth: Code A			
4	Name: LUCI GREGORY Address (HOME): Code A Occupation: Code A Telephone: E-mail address: Date of Birth: Code A			
5	Name: TRUDI JACKSON Address (HOME): Code A Occupation: Telephone: E-mail address: Date of Birth:			

MG 9

RESTRICTED – FOR POLICE, PROSECUTION, AND THE WITNESS SERVICE ONLY

URN:

WITNESS LIST

Date of completion:

* Tick if statement attached

◆ Previous convictions? Enter Y or N

R v

Wit No	Witness Details (In the 'Wit.No.' column enter 'V' if the witness is a victim, 'Vu' if vulnerable or intimidated)	Statement Number	*	◆
6	Name: Code A Address (HOME): Code A Occupation: Code A Date of Birth: Telephone: E-mail address:			
7	Name: Code A Address (HOME): Code A Occupation: Code A Date of Birth: Code A Telephone: E-mail address:			
8	Name: Code A Address (HOME): Code A Occupation: Code A Date of Birth: Code A Telephone: E-mail address:			
9	Name: SIMON MACKIE Address (HOME): Code A Occupation: Code A Date of Birth: Code A Telephone: E-mail address:			

MG 9

RESTRICTED – FOR POLICE, PROSECUTION, AND THE WITNESS SERVICE ONLY

URN:

WITNESS LIST

Date of completion:

✷ Tick if statement attached

◆ Previous convictions? Enter Y or N

R v

Wit No	Witness Details (In the 'Wit.No.' column enter 'V' if the witness is a victim, 'Vu' if vulnerable or intimidated)	Statement Number	✷	◆
10	Name: Code A Address (HOME): Code A Occupation: Code A Date of Birth: Code A Telephone: E-mail address:			
11	Name: RICHARD IAN REID Address (HOME): Code A Occupation: Code A Date of Birth: Code A Telephone: E-mail address:			
12	Name: ARUMUGAM RAVINDRANE Address (HOME): Code A Occupation: Code A Date of Birth: Telephone: E-mail address:			
13	Name: Code A Address (HOME): Code A Occupation: Code A Telephone: E-mail address:			
14	Name: JEANETTE ELIZABETH FLORIO Address (HOME): Code A Occupation: STAFF NURSE Date of Birth: Code A Telephone: HOME Code A E-mail address:			

MG 9

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WITNESS LIST

Date of completion:

* Tick if statement attached

◆ Previous convictions? Enter Y or N

R v

Wit No	Witness Details (In the 'Wit.No.' column enter 'V' if the witness is a victim, 'Vu' if vulnerable or intimidated)	Statement Number	*	◆
15	Name: GILLIAN ELIZABETH HAMBLIN Address (): Occupation: NURSING SISTER G GRADE Date of Birth: Code A Telephone: Code A E-mail address:			
16	Name: LYNNE JOYCE BARRETT Address (HOME): Code A Occupation: STAFF NURSE Date of Birth: Code A Telephone: HOME Code A WORK E-mail address:			
17	Name: ELIZABETH JANE BELL Address (HOME): Code A Occupation: STATE ENROLLED NURSE Date of Birth: Code A Telephone: HOME Code A WORK E-mail address:			
18	Name: Code A Address (HOME): Code A Occupation: Code A Date of Birth: Code A Telephone: WORK Code A E-mail address:			
19	Name: FREDA VAUGHAN SHAW Address (HOME): Code A Occupation: STAFF NURSE Date of Birth: Code A Telephone: Code A WORK E-mail address:			

MG 9

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URN:

WITNESS LIST

Date of completion:

✸ Tick if statement attached

◆ Previous convictions? Enter Y or N

R v

Wit No	Witness Details (In the 'Wit.No.' column enter 'V' if the witness is a victim, 'Vu' if vulnerable or intimidated)	Statement Number	✸	◆
20	Name: IRENE MARGARET DORRINGTON Address (HOME): Code A Occupation: STAFF NURSE E GRADE Code A Telephone: Code A E-mail address:			
21	Name: CHRISTINE ELIZABETH EVANS Address (HOME): Code A Occupation: RGN STAFF NURSE Date of Birth: Code A Telephone: Code A E-mail address:			
22	Name: POLICE CHRISTOPHER SCOTT YATES Address (): Occupation: Detective Constable Code A Date of Birth: Telephone: E-mail address:			

RESTRICTED

Form MG11(T)

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

Statement of: MARTIN-ROGERS, JANET ROSEMARY

Age if under 18: OVER 18 (if over 18 insert 'over 18') Occupation: RETIRED

This statement (consisting of 3 page(s) each signed by me) is true to the best of my knowledge and belief and I make it knowing that, if it is tendered in evidence, I shall be liable to prosecution if I have wilfully stated anything which I know to be false or do not believe to be true.

Signed: J R MARTINROGERS Date: 02/08/2004

I live at the address known to the Police.

I am the only child of Sheila Rosemary GREGORY , born Code A and William GREGORY .

My mother was born just outside of Shaftsbury in Dorset. She was one nine children and had an adopted brother. She had five sisters and three natural brothers. [redacted].

My parents were married in 1932/1933 and lived in Dorset.

William retired early and he and my mother moved to Weymouth. They then moved to Lee-on-Solent and lived in a static caravan.

My mother remained in the caravan after my father died and eventually ended up living at 26 Alec Rose House, Gosport . These were warden assisted flats.

As far as I am aware my mother had an overactive thyroid for which she took tablets all her life. She had some sort of funny turn when was in her late 20's, early 30's and the doctor thought that she had suffered a mild heart attack. I think that around 30 years later she had a similar type of attack.

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My mother was a heavy smoker and smoked around 40 cigarettes a day. She would smoke Woodbines and roll ups, as a result of this she suffered from emphysema for the last 25 years of her life and had inhalers. She stopped smoking around 10 years prior to her death.

My mother had very delicate skin, it would bleed at the slightest knock. Her skin wasn't always this delicate, I think it just happened with old age.

She used to have a lot of bumps and the district nurse would come to her flat to dress the wounds.

In April 1999 my mother fell and broke her hip. She was admitted to Haslar Hospital and underwent an operation to pin it. This operation was carried out under a local anaesthetic because of her breathing problems.

When she returned to the ward and for sometime after she appeared to be very ill. She seemed bloated and she didn't recognise me. She was hallucinating. She kept seeing my father.

As she began to recover from the operation she began to return to normal but I don't think that she seemed to make the same sort of progress as the other ladies who were in her ward and had had the same operation. These ladies were up and about, walking with frames.

I think that my mother was in hospital at Haslar for around 4-6 weeks and during that period I visited her on a couple of occasions.

From Haslar, my mother was moved to the Gosport War Memorial Hospital .

As far as I can remember my mother was always in a ward on her own.

She seemed to be making progress. She recognised me and could hold a conversation. I would visit her on a Tuesday afternoon and although she couldn't walk she no longer had a 'far away

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look'. I didn't know how long she was going to be in hospital but she was getting better. She seemed to like it in the hospital. She didn't complain which surprised me. She had a strong personality and would make her presence felt. She was quite capable of complaining about the nurses, the food, the noise at Haslar but I never heard her moan nor do I remember her complaining about being in pain when she was in the Gosport War Memorial Hospital.

When I used to visit, she would be sat up and dressed in the day lounge with her legs up. I think that she was eating and drinking but I don't know this for sure. I am just assuming that she was.

My mother then had a period when she suffered from diarrhoea, this seemed to go on for a long time. I remember that she needed a bed pan and I asked the male nurse for one. He told me that they were "serving dinner and that she would have to wait". My mother couldn't wait and she soiled herself which upset her a great deal.

Eventually the problem with diarrhoea stopped and she seemed to always be in bed. She appeared to me to be more absent minded, she didn't know what day it was or who had been to see her.

I have been asked if I ever spoke to any member of staff about my mother's health and condition. I didn't ask anyone about my mothers health, no member of staff asked to speak with me and I wasn't told anything but anyone else in my family.

I didn't see my mother immediately prior to her death. I was telephoned by my daughter Pauline who told me that my mother had died.

I have three children, Pauline, Bruce and Trudi .

RESTRICTED

Form MG11(T)

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

Statement of: GREGORY, PAULINE

Age if under 18: OVER 18 (if over 18 insert 'over 18') Occupation:

This statement (consisting of page(s) each signed by me) is true to the best of my knowledge and belief and I make it knowing that, if it is tendered in evidence, I shall be liable to prosecution if I have wilfully stated anything which I know to be false or do not believe to be true.

Signed: P GREGORY Date: 03/09/2004

I live at the address known to the Police. I am the eldest daughter of Janet MARTIN-ROGERS and I have a younger brother Bruce HUTSBY and a younger sister Trudi JACKSON .

My mother's mother was Sheila GREGORY nee PALMER Code A I called her nan.

My nan was one of nine children and her parents adopted a son when she was about 12 years old.

I believe that all of her brothers and sisters are dead with the exception of her sister Joan who may still be alive but I have no other details of her.

My nan married William GREGORY on 4th June 1934 (04/06/1934) and they lived in Shaftsbury. She had one child, my mother. She told me that she had been ill after she had Janet and couldn't have anymore children after that.

Prior to my nan getting married she had been in service as a chambermaid but she stopped work when she married.

My nan was a small slightly built lady. She was considerate, kind, cantankerous and extremely independent.

My grandparents eventually moved to a caravan in Hampshire and after my granddad died in

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1984 my nan continued to live alone in a caravan.

I spent a great deal of my life living with my nan and I called my granddad "dad". I loved my grandparents very much. I would spend every weekend and school holiday with them.

For around the last 9 years of her life she lived in a warden assisted 1st floor flat at Code A

Code A

I have been asked about my nan's medical history.

My nan suffered from some kind of heart attack whilst in her mid to late 30's. She was a very heavy smoker and as a result suffered from emphysema which led to ongoing breathing problems for which she would use an inhaler.

She had an underactive thyroid for which she took tablets.

My nan also had very thin skin. I think this was the result of taking the steroids for her breathing. She would bruise very easily and the slightest knock would cause it to break open.

She was regularly at Haslar Hospital having injuries treated and the district nurse would come to her flat on a weekly basis to redress her wounds.

Around 1989 my nan was admitted to Haslar with breathing difficulties. She was very ill and had to stay in hospital for about a month. My nan was advised to stop smoking and this she did. She was able to return home and continue her life. She remained fully active and mobile.

In July or August 1999 my nan fell and broke her hip. She was admitted to Haslar Hospital in Gosport where her hip was pinned.

This operation was not performed under a general anaesthetic because of my nan's breathing problems. I spoke with the surgeon who carried out the operation and the expectation for my

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nan was that she would recover fully and come home.

My nan stayed at Haslar for about a month, the staff would leave her on a chair where her feet couldn't touch the floor. This caused her pain in her hip and her leg to swell up. The staff put pressure socks on her but they still continued to put her in a chair where her leg received no support.

At this point my nan was eating and drinking and fully alert.

I asked for my nan to be moved to the Gosport War Memorial Hospital because I felt that she would receive rehabilitation treatment.

When she arrived at the Gosport War Memorial Hospital in September 1999, my nan was mobile, but she couldn't walk far and she did have some pain in her hip. I don't know what if any medication she was given for this pain.

My nan was initially very happy at the Gosport War Memorial Hospital. She thought that the nurses were lovely, she was doing her physio and getting about better. She didn't require a catheter and she liked being there after being in Haslar for so long, where she felt the staff were too busy and she didn't like to bother them. I would visit my nan daily and my son Lee , who is also known as Dean, would also visit on a daily basis.

My nan would be sitting in the day room telling all the nurses about us and introducing us to everybody. She had a room to herself and could get about with assistance. She was eating and drinking and making progress.

It was at this time that Lee and I moved nan's stuff from her old flat to a new flat which was nearer to where we lived. Nan was excited and looking forward to coming home.

I then noticed a change in nan. She would be in bed and would have a catheter fitted. I asked the nursing staff "Why" and was told "Because she doesn't want to get up ".

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My nan was still suffering pain in her hip and would avoid doing her daily physio.

I asked staff why she was not going for her physio treatment and was told that she didn't want to or that she "wasn't feeling too good".

I asked the staff why she was spending so much time in bed and was told that "she doesn't want to get out of bed".

The staff didn't seem to be encouraging nan to do things. If she got up then they took her catheter out if she stayed in bed they put it back. She wasn't taken to the toilet or offered a bed pan.

Towards the end of October, beginning of November I was speaking to a Social Worker about them having to let nan's flat go. It was felt that she would need to go to a place where there was nursing care.

At this point I was able to visit daily and spend hours with my nan because I had a back injury and was coming to the hospital for treatment. I had been signed off work for three weeks. I would spend all day with her and then Lee, my son, would come and visit during the evening when he'd finished work.

My nan stopped going into the day room and her room was changed. She stayed in bed all day and didn't eat or drink much, but she'd always had a small appetite. She did drink fruit drinks that I would take in but I felt she could have drunk more.

I spoke to the staff about this but was told that "they don't make them eat if they don't want to" and that "they are at the time of their life that they can do as they please".

My nan showed me a tube that went into her stomach. She said that they put painkillers in it. She had massive bruises on her arms from where they took her blood so I thought the tube was

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there because her skin was thin and frail. She was still fully alert but could sometimes be a little forgetful. She may not recall who had visited her the day before. She was always happy to see me but seemed low in spirits. She was fed up and bored. She told me that she had "had enough now" and that she wasn't going to get any better. I didn't have any concerns about the way she was talking because she'd had enough for years and had been saying things like it regularly since granddad died. She told me that she had seen granddad standing at the bottom of her bed.

Some days she would be slumped and distressed and on other days she would be cheerful and chatty. Sometimes she didn't want to talk and would be hard work to visit and others would be bright as a button.

A couple of weeks before she died I spoke with her about having to let the new flat go and the possibility of her going into a nursing home. She didn't want to go into a home and live with "old people" so we talked about a halfway assisted home.

Our expectation was that she would leave the hospital possibly before Christmas.

On Saturday 20th November 1999 (19/11/1999) I visited her early on in the day and again in the early evening, when she was sat up in bed, wearing a pink bed jacket. Her hair was all fluffed up and she was happy and bright and alert. We joked about her wearing pink, a colour she didn't like She was as bright as a button and telling me that Bruce and his daughter Stephanie had visited. She was happy and laughing. She was alert and lucid. She didn't complain of being in pain, nor did she appear to be suffering any pain.

On Sunday 21st November 1999 (21/11/1999) when I visited my nan she was lying on her side, drowsy and didn't seem to be with it. She didn't chat and I remember just sitting.

Lee and his girlfriend Lucy came in and I think that Trudi did. We didn't stay long with my nan and we all went to her new flat to pack her things up and clear out her flat as she wouldn't be going there.

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On Monday 22nd November 1999 (22/11/1999) I had to go to the physio at the hospital so I called in to see my nan. This was around 10am (1000). My nan was lying on her back breathing normally. I held her hand and it didn't feel like nan. She didn't stir, she didn't wake up and she didn't squeeze my hand. She didn't seem like my nan, it was like she was unconscious.

I stroked her hand and gave her a kiss and then I left her.

Around 5.30pm (1730) that evening I was rang by Lee and told that my nan had died.

I went and told Bruce and Trudi later that evening.

My nan had arranged her own funeral some time before and she is buried at Anns Hill Cemetery in Gosport.

Taken by:DC Code A ROBINSON

[redacted]

[redacted]

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Form MG11(T)

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

Statement of: GREGORY, DEAN LEE

Age if under 18: OVER 18 (if over 18 insert 'over 18') Occupation: MECHANIC

This statement (consisting of page(s) each signed by me) is true to the best of my knowledge and belief and I make it knowing that, if it is tendered in evidence, I shall be liable to prosecution if I have wilfully stated anything which I know to be false or do not believe to be true.

Signed: D L GREGORY Date: 23/08/2004

I live at the address known to the Police.

I am the only child of Pauline GREGORY , the great grandson of Sheila GREGORY and the nephew of Trudi JACKSON .

I always called Sheila "little nan" because of her size and I call Janet ROGERS , my mum's mum, "big nan".

I have always been very close to "little nan". She looked after my mum when she was growing up and then she looked after me. I loved my "little nan" very much. I visited her regularly when she lived in her flat and I visited her virtually every day when she was in hospital.

In 1999 "little nan" fell and broke her hip. She was taken into Haslar Hospital and had an operation to pin it. She wasn't able to have a full anaesthetic because she had problems with her breathing. I think it was because of this that she took such a long time to get over it and 'come round' in Haslar.

I visited her every day whilst she was there and I knew that she was in pain and had medication for it. Initially she seemed to be hallucinating but as the weeks went on she got better and had all of her faculties back.

Little nan was moved to the Gosport War Memorial Hospital for physiotherapy and rehabilitation after a few weeks in Haslar . She was going home to a new flat and they wanted

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to get her mobile. I visited my "little nan" every day during my lunch hour. I would often find her sitting in the lounge. She would be dressed in her nightie. Initially she was cheerful and happy. She was alert and in good spirits. She was walking with a frame. I remember that there was a black male nurse who used to go walking with her.

Little nan loved the staff. She behaved towards them like she knew them really well as if they were friends.

When "little nan" had been in Haslar her ankles had been swollen but they seemed to get worse at the Gosport War Memorial Hospital.

Later when I would visit I would find her in bed, the staff were not getting her up and her ankles got more swollen. I told the staff to get her up but they said that she would refuse to get up walk. I told them to ignore her and make her walk but little nan was very strong willed and did what she wanted to do.

Little nan changed rooms a few times whilst she was at the Gosport War Memorial Hospital.

At one stage she suffered from diarrhoea and was quite ill. I remember that she needed to go to the toilet but the staff didn't come and she messed herself. She was very upset by this. She became very weak and struggled to eat and drink. She seemed to be losing interest with things as if she couldn't be bothered anymore. She was very tired and was either asleep or falling asleep all the time.

She had a drip going into the back of her left hand. I remember that there was a massive bruise. She needed oxygen and was very short of breath. She was moved beds in this room and I remember lying next to her on this bed, holding her. I used to feed her water. I thought that she might die.

Whilst she was in this bed she was still sleepy but she did seem to wake up.

RESTRICTED

From this room little nan was moved to a single room by the other lounge. This room had different nurses and the lounge had different patients to the other lounge although it was it the same ward.

Little nan didn't like the "new nurses" or the "new patients". She recovered enough to go into the new lounge. I remember how I thought that she was losing it. She seemed to be getting paranoid. She thought that everyone hated her. Little nan could be abrupt and she felt that the new people didn't like her. She refused to eat and would get agitated and frustrated.

She wouldn't eat the hospital food and the staff would come and take it away untouched. No one tried to get her to eat.

A week before little nan died I got a phone call from one of the nurses at the hospital. She told me "Come and visit as much as you can, it won't be long". By this, I thought, she meant that it wouldn't be long before "little nan" died.

I told my mum about this and continued to visit little nan every day.

I visited little nan that evening and she was asleep. She looked frail and tiny. I held her hand and she acknowledged that I was there but she didn't wake up.

During the following days little nan seemed to "perk up" in her spirits but she never got up again. I would sit and chat to her. She used to like watching her soaps. I remember sitting and watching Eastenders with her.

On Sunday 21st November 1999 (21/11/1999) I spent a long time at the hospital with "little nan". My Uncle Bruce came to visit with Stephanie , his daughter and he broke down at the sight of little nan. She looked so small in the bed.

Little nan woke up whilst Bruce was there and she was pleased to see him. She got tired very quickly and though I took her hand, she barely held mine.

RESTRICTED

On Monday 22nd November 1999 (22/11/1999) I was at work when I got a telephone call from the hospital, it was around 1030 am. It was from the same nurse who had rung me earlier. She told me "Come in and say goodbye". I walked out of work and went straight to the hospital.

The nurse who had rung met me and took me to little nan's room. She was very sympathetic and left me with her.

I kissed my little nan but she was "out of it" sound asleep. I said my goodbyes to her and then I went back to work.

Around 5.30pm (1730) I got a phone call from the hospital to tell me that little nan had died.

I don't know why little nan died. She was not ill, she was a strong fit woman who had broken her hip. I didn't want to think that something was wrong with the way that she had died.

My Aunt Trudi said straight away that something was wrong and she was very angry. I didn't want to upset my mum anymore than she was already so I didn't say anything.

My little nan is dead and nothing can change that. I found the whole experience very upsetting. I was twenty when it happened and I try not to think about it.

I remember that my nan had liked the first lot of nurses and they had always been kind to me so afterwards I took them in a thank you card. I now find it quite upsetting to think that I might have said thank you to people who harmed my little nan.

RESTRICTED

Form MG11(T)

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

Statement of: GREGORY, LUCI

Age if under 18: O.18 (if over 18 insert 'over 18') Occupation: LOAN PROCESSOR

This statement (consisting of 3 page(s) each signed by me) is true to the best of my knowledge and belief and I make it knowing that, if it is tendered in evidence, I shall be liable to prosecution if I have wilfully stated anything which I know to be false or do not believe to be true.

Signed: L Gregroy Date: 02/06/2005

I am the above named person and I live at the address shown overleaf. I am the wife of Dean GREGORY who I have known for seven years, since February 1998.

Dean was very close to his great grandmother, Sheila GREGORY . He would call her "Little Nan" and would visit her all the time. He would visit her during lunch breaks and after work. I would say he saw her most days. It was through Dean that I got to meet Sheila.

She was a lovely lady who knew her mind. When I first met her she was very independent and would walk into Gosport by herself. She had a large circle of friends and what I would describe as a good quality of life.

I don't recall the date but as a result of a fall Sheila was taken to Haslar Hospital . She had damaged her hip and underwent an operation. After the operation all seemed to be going quite well. She could walk with the aid of a walker and seemed to be getting better and quickly as one might hope.

I think Sheila was at Haslar for about five or six weeks. I would visit her with Dean and sometimes on my own. She seemed well cared for and I don't think anyone had any concerns about her welfare.

After Sheila left Haslar she was taken to the Gosport War Memorial Hospital (GWMH). I don't recall the name of the ward. I thought she was going there very much as a half way house to help her to get stronger so she could move into a flat again. Everyone in the family expected

RESTRICTED

her to be well enough to leave at the end of her stay.

At first I think Sheila was in a ward but at some stage she went into a private room, she was certainly moved a couple of times. I do recall Sheila stating she had some pain with her hip but it was something that was managed.

Whilst at the GWMH, Sheila had good days and bad days. I thought she was meant to be getting better but there were days when clearly she had not got out of bed. Her food would be left in the room, none of the staff would help her eat and there was a general lack of encouragement. This struck me as a common theme in the ward.

I do recall one old woman calling out for help to use the toilet. The staff just left her and it was clear she was very upset. I went over to the staff, who said,

"She is always like that". I found this very uncaring.

I don't remember how long Sheila was at the Gosport War Memorial before she died. I do recall Dean getting a call on a Friday to say she had taken a turn for the worse. Dean and me spent most of the weekend with Sheila. However she was very out of it and unable to speak. She seemed every drugged up. Before this weekend she had been very lucid.

I couldn't see anything wrong with Sheila, her hip seemed to be on the mend so there was no reason why she should be so drugged. The rest of the family felt the same. From the family Dean and his mother Pauline had most conversation with the nursing and hospital staff.

I think Sheila died on the Monday after the weekend. I don't know what her cause of death was. Nor do I recall her being ill with anything that could have caused her death.

Looking back her death was very sudden and unexplained. We all thought she would come out of the GWMH and move into a flat.

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Form MG11(T)

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

Statement of: JACKSON, TRUDI

Age if under 18: OVER 18 (if over 18 insert 'over 18') Occupation: HOUSEWIFE

This statement (consisting of page(s) each signed by me) is true to the best of my knowledge and belief and I make it knowing that, if it is tendered in evidence, I shall be liable to prosecution if I have wilfully stated anything which I know to be false or do not believe to be true.

Signed: T JACKSON Date: 03/08/2004

I live at the address known to the Police.

I am the daughter of Janet MARTIN ROGERS and the grand daughter of Sheila GREGORY. I have a sister Pauline and a brother Bruce .

My nan was a proper nan, she was strict and she was straightforward. I felt safe with her. She was very independent and everyone in the area knew her, she had a sharp tongue and would use it.

She never wore dresses, she was always in leggings and tee shirts. If you went to her flat and were hungry then she'd give you a pot noodle. She wasn't like other people's nans.

She had spent the last twenty years on her own and sometimes she could be nasty to people.

I was close to my nan although Pauline my sister was her favourite. My nan would talk to me about what she wanted to happen when she died, her wishes. These conversations took place in her flat before she went into hospital.

I have been asked if I can remember anything about my nans medical history. My nan suffered from emphysema, she had to use inhalers. I recall that she had to go into Haslar some years ago because she had problems with her breathing. I remember that she was in bed with a mask on her face. She recovered and was discharged, this was the time when she gave up smoking.

RESTRICTED

In 1999 my nan broke her hip and had to go into Haslar Hospital.

I visited her about a week after she had been admitted and she didn't seem like my nan. She was bloated and very vague. She didn't seem to know me and I found visiting her there to be upsetting so I didn't go regularly.

I did visit her a week before she was moved to the Gosport War Memorial . She seemed much better but she was still not my nan. I felt that she had lost her fight. She had lost her edge.

I cannot remember the exact dates but I believe my nan was in Haslar for about seven weeks and then she was moved to the Gosport War Memorial.

I would visit my nan in Daedalus Ward with my mum on a Tuesday. My nan would normally be sitting out in the day room. I noticed that she would be dressed in dresses which was very unusual for her. She normally wore leggings. Normally this would have annoyed nan and she would have complained but she never mentioned anything about it.

My nan seemed to be good tempered but fed up in the Gosport War Memorial.

She was quiet and couldn't move in her chair. I don't recall her saying that she was in pain but I remember that she would flinch as if she was in pain and she didn't seem chesty.

After she had been in the GWMH for about three to four weeks when she suffered from a bad case of diarrhoea. She was put in a room on her own. I remember that she was left for too long when she needed a bed pan and she messed herself. She was very unhappy about this.

From this time she remained in a room on her own although at one stage she was moved to a single room by where the nurses sit (nursing station). At this point nan was drinking but I never saw her eat. She was talking and lucid. She could hold a conversation and was able to make sense.

RESTRICTED

A couple of days before nan died I visited her and she told me that she had seen my granddad at the foot of her bed and that she had had enough. I told her that my granddad was waiting for her and to go with him.

A few days later I cannot recall the date I received a telephone call from Pauline. She told me that I should go and see my nan as she was "not looking good".

I went to see her that afternoon and she was sat up in bed chatting to other members of my family. She was propped up on her pillows. I recall that Bruce was there with his daughter Stephanie, Pauline and possibly her son Dean .

My nan was in good spirits. She was lucid and cheerful. I held a cup of tea whilst she drank it.

I noticed that my nan had some sort of tube going into her belly button. I didn't see that it was attached to anything. My nan told me that it was for pain killer.

During the afternoon we were asked to leave the room by a couple of nurses. I don't know what they were doing but they were only with my nan for between 5-10 minutes.

When I went back into the room my nan was lying down and only had one pillow under her head. I noticed that her breathing had become more laboured. I have worked with elderly people and I know the sound of what I would call "death rattle". The noise of breathing people make just before they died. My nan's breathing was not like this it just sounded laboured.

I then told my nan that I loved her and that I would be back and I left the hospital to see to my family and get something to eat.

As I left the ward I asked the nurse if she thought that my nan would 'go' in the night. By this I meant would my nan die. The nurse replied quite abruptly "be quiet, she can hear you, you know".

RESTRICTED

I left the hospital intending to return later that day but around 7.30 (1930) - 8.30 (2030) pm Pauline arrived at my home and told me that my nan had died.

I contacted the hospital the following day in order to arrange to see my nan and they told me that I should wait until my nan was in the Chapel of Rest. I eventually went to the Chapel of Rest and saw my nan. I think this must have been 2/3 weeks after she had died and I think the delay was due to it being Christmas.

I noticed that my nan had a thick red line like a cut on the left hand side of her face by her lip. I asked the undertaker how she had come to be marked and he didn't know. I thought that it might have been where they had tried to put her teeth in but my nan wasn't wearing her teeth.

I have always thought that the circumstances of my nan's death were not right. I felt that she died very suddenly.

[redacted]

[redacted]

RESTRICTED

Form MG11(T)

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

Statement of: Code A

Age if under 18: (if over 18 insert 'over 18') Occupation: RETIRED GENERAL PRACTITIONER

This statement (consisting of 5 page(s) each signed by me) is true to the best of my knowledge and belief and I make it knowing that, if it is tendered in evidence, I shall be liable to prosecution if I have wilfully stated anything which I know to be false or do not believe to be true.

Signed: W.A Harrison Date: 05/07/2005

I am Code A a retired GP, I live at an address known to Hampshire Police.

In 1969 I qualified at the Royal Dental Hospital, Leicester Square, London WC2. I obtained a BDS (London) which is a Batchelor of Dental Surgery. The same year I also obtained a LDS RCS which is Licentiate in Dental Surgery of the Royal College of Surgeons of England.

From 1969 to 1975 I practised part time in the Oral Surgery department of Dublin Dental Hospital as during this period I was studying medicine at the Royal College of Surgeons in Ireland.

In 1975 I qualified as a LRCP. LRCS and LM (I)

L RCP which is a Licentiate of the Royal College of Physicians of Ireland.

L RCS which is a Licentiate of the Royal College of Surgeons of Ireland.
LM (I) which is a Licentiate in Midwifery, Ireland.

From July 1975 until June 1976 I undertook two pre-registration House Officer 6 month posts in the Professorial Medical and Surgical units at the Charitable Infirmary, Jervis Street, Dublin which is the hospital where I trained.

I then completed a further year as a Medical Senior House Officer (SHO) in Gastroenterology and Cardiology at the Charitable Infirmary.

RESTRICTED

In 1977 I returned to the United Kingdom where I took up a Medical Registrar's post in the Manor and George Elliot hospitals in Nuneaton, Warwickshire. The Consultant Physician for whom I worked was Doctor Bernard Smits F.R.C.P (Now deceased)
In 1978 I left hospital Medicine to undertake a GP training year with the Measham Medical practice in Measham, near Ashby de La Zouche, Leicestershire. During this period the training included 1 month of each in, Obstetrics, Geriatrics, Ophthalmology, Psychiatry and Paediatrics in Burton on Trent and Leicester Royal Infirmary as a supernumerary Senior House officer.

Also included, within this training year, were 6 months of day to day General Practice work.

In 1979, I took up the appointment, of Principal in General Practice, at 69 Bury Road, Bury Road Surgery, Gosport as a partner to Dr Alistair MACLEAN and Dr Nicolas HAJIANTONIS
.

From 1981 until 1984 I was also employed as a Clinical assistant in Dermatology at the Basingstoke District Hospital for a half day each week.

This practice covers the Gosport peninsula area.

My General Medical Council no was Code A

My British Medical Association no was Code A

I was a partner at the Bury Road Practice from 1979 until my retirement in September 2003.

I have been asked to detail my involvement with the patient Sheila GREGORY Code A

I can remember this lady reasonably well. As I recall she was a very pleasant lady originating from Dorset. Her mental ability for her age was excellent with no obvious signs of dementia.

RESTRICTED

She registered at the Practice on 31/12/84 and was first seen on 28/01/85. She visited the Practice infrequently. I have checked her medical notes (exhibit ref TAS/4) . I note that she attended once every 4 months during the period 1996 to 1999.

She was on long term medication for an under active thyroid gland and a mild hypnotic as she was an insomniac.

Sheila GREGORY was suffering with; 1) chronic obstructive pulmonary disease (COPD) which she had had for many years secondary to smoking. 2) valvular heart disease. 3) A mild anxiety state leading to insomnia.

Sheila GREGORY was allergic to Septrin (Co-trimoxazole) and Penicillin. These allergies were clearly marked on the front of her medical records- (commonly known as Lloyd George Folders).

Her routine medication was as follows:

1) Thyroxine 100 mcg 1x day. This was prescribed for the treatment of hypothyroidism (Under active Thyroid).

2) Salbutamol 2 puffs (PRN) i.e. when required. She was using the inhaler for Chronic Obstructive Pulmonary Disease (COPD)

3) Beclaforte inhaler 250 mcgs. 4 puffs twice a day. She was prescribed this for COPD

4) Atrovent 250 mcgs 2 puffs twice a day. She was prescribed this for COPD

5) Zimovane 7.5 mgs 1 taken at bed time. She was prescribed this for insomnia

This was the drug regime that she had been on, prior to her admission to hospital.

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From referring to her medical notes I can confirm that I was asked to see Sheila GREGORY on the 15/12/98. I attended to her at her address of flat Code A

Code A

On taking her history, she stated that she had been breathless for 2 days and now could not lie down.

Following examination I diagnosed that she had bilateral pneumonia predominantly in her left lung and was in left ventricular failure.

As a result of my examination I arranged for her to be admitted to the Elderly Medical Unit at the Queen Alexandra hospital forthwith.

However, I note that when, the ambulance crew arrived, about 1 hour after I had left, they were very concerned with her condition and took her immediately to the Accident and Emergency (A&E) department at Haslar hospital.

I was subsequently notified of these facts by the ambulance service.

She was eventually admitted to A6 ward under the care of Surgeon Captain W.M. EDMONDSTONE R.N. M.D. FRCP Consultant physician in Respiratory Medicine.

I had no further dealings with Sheila GREGORY personally after this date.

I note from her medical records that on 29/05/99 she was prescribed the following medication as a repeat prescription by Dr Nicolas HAJIANTONIS , a partner in my practice.

Thyroxine tablets 100 mcg one to be taken daily.

RESTRICTED

Form MG11(T)

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

Statement of: Code A

Age if under 18: OVER 18 (if over 18 insert 'over 18') Occupation: RETIRED GENERAL PRACTITIONER

This statement (consisting of 3 page(s) each signed by me) is true to the best of my knowledge and belief and I make it knowing that, if it is tendered in evidence, I shall be liable to prosecution if I have wilfully stated anything which I know to be false or do not believe to be true.

Signed: Code A Date: 10/11/2005

I am a retired General Practitioner and live at the address stated overleaf. My qualifications are as follows:

Medical Diploma, University of Athens 1965.

MRCOG 1974.

LMSSA of London 1976.

My career history is as follows:

1966 - February 1974 Obstetric Gynaecologist, Greenock.

February 1974 - March 1975 SHO in Anaesthetics, Gloucester.

April 1975 - March 1978 Registrar in Obstetric Gynaecology, Ashford, Kent.

April 1978 - September 2005 (On retirement) Principal in General Practice at The Surgery, Bury Road, Gosport.

I have been asked if I recall a patient named Sheila GREGORY , I have no clear memory of her but I do have a vague recollection. I have been shown a copy of her surgery notes labelled TAS/4 . From the clinical notes cards I see that she joined the surgery as a patient in 1984. I saw her several times over the years, as per the following précis:

24/02/86 Home visit as a follow up to being seen by another doctor the previous night, she was chesty, I prescribed cough mixture and Paracetamol.

Signed Code A Signature Witnessed by:

RESTRICTED

19/04/86 Seen at surgery with lower back pain, Ibuprofen and liniment prescribed.

25/07/87 Seen for conjunctivitis, she was given eye drops and ointment.

19/06/88 Seen at home for a chest infection and breathlessness, prescribed antibiotics.

23/12/1989 Seen at home for chest infection, prescribed antibiotics and cough mixture.

1/09/90 Seen at home for a chest infection and wheeziness. She was given antibiotics and an inhaler.

27/10/90 Seen at surgery, she refused to have a flu jab, repeat prescription for inhaler.

29/01/91 Seen at home, she had fallen a week ago, coughing and chesty. Prescribed painkillers and antibiotics.

16/02/1991 Seen at surgery for repeat prescription of Thyroxin for her under active Thyroid.

07/08/91 Seen at home, bruising easily, sore mouth. Ordered blood tests, repeat prescription for inhalers, thyroxin and sleeping pills.

08/09/93 Emergency visit to surgery complaining of dizziness, she was prescribed Stemetil and given a repeat prescription for her heart pills and inhaler.

10/12/93 Seen at home, pain in her lower ribs and she had the shivers (Urinary Tract Infection), she was prescribed antibiotics.

19/04/94 Attended surgery for results of her chest x rays which had been ordered by Dr HARRISON, they were not available.

22/06/94 Seen at home, she had knocked her lower leg 2 days previously causing superficial

RESTRICTED

lacerations, too late for stitches so her leg was dressed and I arranged for her to see the District Nurse.

02/08/94 Seen at surgery, she had bruising, blood tests arranged and repeat prescription of Thyroxin and Stemetil.

01/09/94 Seen at surgery, blood test results were all normal so she was reassured.

31/10/94 Seen at home, she had recently had two falls and had a low pulse. Reduced her Digoxin and gave her a flu jab.

13/01/95 Seen at home, she'd had headaches for 2-3 days and her blood pressure was raised. Prescribed painkillers.

11/10/95 Message received from casualty that she had fallen and had bruising to her legs, which had been bandaged. Arranged to be seen by District Nurse.

16/04/96 Seen at home, she had tiredness and no energy. Nothing found on examination so she was reassured.

07/11/96 Seen at home, she had fallen 4 days previously, on examination nothing was found, she was prescribed painkillers and given a flu jab.

29/05/99 I repeated her prescription for Thyroxin.

This was the last entry on her cards. I do not believe that I had any further dealings with Sheila GREGORY.

RESTRICTED

Form MG11(T)

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

Statement of: Code A

Age if under 18: (if over 18 insert 'over 18') Occupation: RETIRED CONSULTANT

This statement (consisting of page(s) each signed by me) is true to the best of my knowledge and belief and I make it knowing that, if it is tendered in evidence, I shall be liable to prosecution if I have wilfully stated anything which I know to be false or do not believe to be true.

Signed: Code A Date: 21/07/2005

I am a retired Consultant Orthopaedic Surgeon. I live at an address known to the Hampshire Police.

In 1962 I graduated from Agra University, India. I obtained a Bsc which is a Batchelor of Science Degree.

In 1970 at Banaras University, Banaras, India, I obtained an M.B.B.S which is a Batchelor of Medicine and Surgery.

In 1973 at Lucknow University, Lucknow, India, I obtained an M.S (ORTH) which is a Master of Surgery in Orthopaedics.

In June 1984 I became a member of the Royal College of Physicians and Surgeons at Glasgow, Scotland.

Between January 1970 and June 1972 I was Resident in Orthopaedics at the King George Medical College, Lucknow University, Lucknow, India.

From July 1972 until March 1974 I was employed as Senior and Chief Resident in Orthopaedics at Lucknow University, Lucknow, India.

Between November 1974 and May 1975 I was employed as a Consultant Orthopaedic Surgeon at the District General Hospital, Lucknow, India.

RESTRICTED

From May 1975 until January 1977 I was employed as a Consultant and Lecturer in orthopaedics at the Medical College at the Allahabad University, India.

Between February 1977 and February 1984 I was employed as Senior House Officer at Frenchay Hospital, Bristol.

During this period I was Senior House Officer in General Surgery at the Solihull Hospital, Solihull, Birmingham.

I was Senior house Officer in Accident Surgery at the Corbett Hospital, Stourbridge.

I was Senior House Officer Orthopaedics for Surgical fellowship at the Sandwell Hospital, West Bromwich.

From March 1984 until March 1986 I was employed as Registrar in Orthopaedic Surgery at the Dudley Road teaching hospital in Birmingham.

Between April 1986 and December 1988 I was employed as Registrar at the Kidderminister General Hospital, Kidderminster.

From January 1989 until November 1991 I was employed as Registrar in Orthopaedic Surgery at the Selly Oak Hospital, Birmingham.

Between August 1991 and July 1996 I was employed as a locum Consultant in Orthopaedics and Trauma at a variety of hospitals in and around the Birmingham area.

From August 1996 until September 1997 I was employed as a Consultant in Trauma and Orthopaedics at the British Military Hospital, Rinteln, Germany BFPO31.

Between May 1998 and June 1999 I was employed as a Consultant in Trauma and Orthopaedics

RESTRICTED

at the D.K.H Military Hospital, Catterick, North Yorkshire.

From July 1999 until August 2000 I was employed as a Consultant in Trauma and Orthopaedics at the Royal Hospital, Haslar , Hampshire.

Between October 2000 and July 2002 I was employed as a Consultant in Trauma and Orthopaedics at the British Military Hospital, TMPH, Akrotiri, Cyprus.

I produce my Curriculum Vitae as exhibit PSM/1

I have been asked to detail my involvement with the patient Sheila GREGORY dob 12/07/08

I can confirm that on the 16th August 1999 I was employed as a Consultant Orthopaedic surgeon at the Royal Hospital, Haslar.

I do not remember this patient.

From referring to the medical notes page 62 (exhibit JR/12) I can confirm that on 16/08/99 I conducted a ward round in my capacity as a Consultant Orthopaedic Surgeon. I was accompanied by Dr A. WEST.

The notes read as follows;

0845 16/8/99 W/2 Code A
For (R) DHS - Some pain otherwise independent
Consented + marked
Gentle fluids - I/V - (illegible)
X ray matched- (illegible)

I believe these notes were written by Dr Andrew WEST.

RESTRICTED

To clarify this entry, a ward round has been conducted prior to surgery to prepare Sheila GREGORY for the operating theatre. Her right leg was marked with a skin marker pencil. Her consent for the operation was obtained.

The operation was conducted the same day 16/08/99.

From referring to the Medical notes (exhibit ref JR/12) I note that on the 16/08/1999 I supervised and assisted in the Operating theatre at Haslar hospital with a Dynamic Hip Screw (DHS) procedure to Sheila GREGORY who had suffered a fractured neck of Femur. It was a routine operation with no complications. The operation involved inserting a 5 hole plate with a 75mm screw for fracture fixation. Two drains were fitted into the wound to assist in the drainage of fluids.

At the completion of the operation the patient was placed on E3 an Orthopaedic ward.

I can confirm that on the 17/08/99 I conducted a post operative ward round.

This entry on page 62 of the medical records (exhibit JR/12) reads as follows; (This entry I believe has been written by Surgeon Code A)

W/R Mr Code A
Well Post-op *plan (1)Check X-ray today*
(2)FBC, U&E

The plan was to ensure that the X-ray was seen and recorded.

FBC - Full Blood Count -This was to check Post Op mainly the levels of her Haemoglobin (white blood cell) count.

U&E - Urine and Electrolyte -This was to assess her electrolyte balance i.e. Sodium, Potassium levels.

RESTRICTED

As a result of this request, a report detailing the patient's Full Blood Count (FBC) and Urine and Electrolyte (U&E) was obtained which is as follows;

FBC

Hb= Haemoglobin 9.4 (This is normal for a person this age post Op)

WBC = White Blood Count 8.18 (This is a normal reading)

Plt = Platelet 187 (This again is normal)

U&E

Na+ = Sodium 133 (This is slightly low)

K+ = Potassium 5.0 (This is normal)

Bicarb = Bicarbonate 26 (This is normal)

Urea 5.5 (This is normal)

Creatine 90 (Satisfactory though slightly raised)

These results were within the normal limits for someone recovering after an operation.

From referring to the medical notes (page 63 of exhibit JR/12 refers) I can confirm that I conducted a Ward Round on the 19/08/99 which reads as follows;

(This entry was possibly written by Surgeon Code A)

2/7 = (2 days after Op i.e. Post operation)

Afibrial = (Normal Temperature)

Mobilising slowly = (i.e. to encourage movement)

Encourage Oral Fluid = (By mouth)

From referring to the medical notes (page 63 of exhibit JR/12 refers) I can confirm that I conducted a ward round on the 23/08/99. The entry I believe has been written by surgeon Lt Code A which reads as follows;

RESTRICTED

1/52 post ® DHS

Progressing well

Can only walk with assistance

Feels generally well in herself

Plan (1) (Cont) gradual mobilisation

(2) Refer to GWMH for period of rehab

To clarify this entry, the patient has progressed well since the operation. There were no complications with regards to the Right Dynamic Hip Screw procedure. The plan was to transfer the patient to the Gosport War memorial hospital for further rehabilitation. I have requested that a Consultant Geriatrician assess the patient for transfer and rehabilitation.

I note that Dr TANDY a Consultant Geriatrician examined and assessed Sheila GREGORY on the 23/08/99.

I can confirm that on the 25/08/99 (page 83 exhibit JR/12 refers) I conducted a ward round with Surgeon Lieutenant Code A the entry reads as follows;

9/7 (9 days Post Op) ® *DHS*

Mobilising slowly with assistance from physios

Awaiting transfer to GWMH

Temp 37.5

Plan - as above

- *CXR* (Chest X-ray) *MSU* (Midstream Urine Examination)
- *FBC* (Full Blood Count) *ESR* (Erythrocyte Sedimentation. This is process involving a Centrifugal check to ascertain if there are any infections or chronic conditions)

I can confirm that on the 31/08/99 (page 86 exhibit JR/12 refers) I conducted a ward round with Surgeon Lieutenant Code A the entry reads as follows;

RESTRICTED

W/R Mr MISRA

ROS (Removal of Suture) - *wound healing well*

Mobilising Slowly- awaiting bed at GWMH

Temp 37.5 (This is marginally raised) *Otherwise well ° Cough* (No cough) *chest clear*

Plan

1) *Encourage oral fluid intake*
2) *Repeat U&E's tomorrow*
3) *Stop oral Abs* (Antibiotics)
4)

To clarify this entry, the patient had a marginally raised temperature. Her chest was clear there was no evidence to suggest a DVT. (Deep Vein Thrombosis)

DVT and Chest infections are the two most important post operative complications. Therefore checks are conducted.

I note that the patient was on Erythromycin an antibiotic which was commenced on 27/08/99.

I had no further dealings with this patient after this date.

To summarise this patient- She was an elderly lady who had a routine right Dynamic Hip Screw operation with no serious complications.

She stayed in the hospital for approximately 2 weeks during which she was mobilised with the help of a physiotherapist.

She was given precautionary treatment for DVT and chest infection.

Her medical records show that she was transferred to the Gosport War Memorial hospital on the 03/09/99 as planned.

RESTRICTED

Form MG11(T)

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

Statement of: Code A

Age if under 18: OVER 18 (if over 18 insert 'over 18') Occupation: SPECIALIST REGISTRAR

This statement (consisting of 9 page(s) each signed by me) is true to the best of my knowledge and belief and I make it knowing that, if it is tendered in evidence, I shall be liable to prosecution if I have wilfully stated anything which I know to be false or do not believe to be true.

Signed: S MACKIE Date: 17/10/2005

I am Code A I reside at the address detailed overleaf. In 1995 I graduated from University College London. I obtained an MBBS which is a Batchelor of Medicine and Surgery. I became a member of the Royal College of Surgeons in October 2001.

In 2004 I obtained an MSc in Urology at the institute of Urology and Nephrology, University College London.

My General Medical Council registered number is Code A

Between August 1995 and November 1995 I was House Officer (General Surgery) at University College London.

From November 1995 until February 1996 I was House Officer (Orthopaedics) at University College London.

Between February 1996 and June 1996 I was House Officer (General Medicine and Gastroenterology) at Royal Hospital, Haslar.

From June 1996 until August 1996 I was House Officer (General and Respiratory Medicine) at Royal Hospital, Haslar.

Between September 1996 and August 1999 my Royal Naval General duties involved working as a Medical officer on HMS Westminster, as Deputy Principal Medical Officer at HMS Raleigh

RESTRICTED

and as Medical Officer on HMS Iron Duke.

I held the post of Surgical Senior House Officer between August 1999 and February 2000 in Orthopaedics at Royal Hospital Haslar.

Between February 2000 and August 2000 I was Senior House Officer at Queen Alexandra Hospital, Portsmouth.

From August 2000 until February 2001 I was Senior House Officer in General and Upper GI Surgery at Queen Alexandra Hospital, Portsmouth.

Between February 2001 and August 2001 I was Senior House Officer in Urology at Royal Hospital Haslar.

From August 2001 and February 2002 I was Senior House Officer in Plastic Surgery at Royal Hospital Haslar.

Between February 2002 and August 2002 I was Senior House Officer in Vascular Surgery at Queen Alexandra Hospital.

From August 2002 and November 2004 I was Urology Research fellow at Portsmouth Hospitals NHS Trust.

Since November 2004 I have held the position of Specialist Registrar in Urology at Ninewells Hospital, Dundee.

I have been asked to detail my involvement with the patient Sheila GREGORY Code A I do not remember this patient or the subsequent treatment that was administered.

I have been shown the medical records relating to this patient exhibit reference JR/12. I can confirm that I have written the following entry on page 83 of the Haslar Medical records.

RESTRICTED

25/8/99 *9/7 post ® DHS*

Mobilising slowly with assistance from physios.

Awaiting transfer to GWMH

Temp 37.5

Plan - As above

- CXR, MSU

- FBC, ESR, TFT's

Surg Lt Code A

I can confirm that I have written the following entry on page 84 of the medical notes;

27/8/99 *Hx noted*

Temp 37.5

® leg Swollen - ° calf tenderness - °warmth/ redress

Plan - TED stockings if will tolerate.

- CT low molecular wt Leparin

- Start Erythromycin

- ROS over wk/end

Surg Lt Code A

I can confirm that on page 85 of the Haslar medical records I have written the following entries:

27/8/99 *→ No MSU*

TFT's as 'recorded' - ↓ free T3

H6 105 *Na+ 134* *creat 71*

WCC 8.23 *K+ 4.1*

PLT 454 *Bicarb. 29*

ESR 12 *Urea *6.6 (↑)*

CXR *- as above.*

Plan *-1) Erythromycin started blindly to cover possible respiratory infection.*

2)Repeat MSU.

3)Encouraged oral fluid intake

RESTRICTED

4)Discuss ↓ T3 with physicians?

Surg Lt Code A

27/8/99

- D/W Medical registrar

Advised repeat TFT's 4-6/52

Surg Lt Code A

28/8/99 W/R Reg.

No change - temp 37.0

Plan as above

Surg Lt Code A

I can confirm that on page 86 of the medical records I have written the following entries:

31/8/99

W/R Mr MISRA

ROS - wound healing well

Mobilising slowly - awaiting bed at GWMH

Temp 37.5. Otherwise well. ° Cough chest clear.

Plan 1) Encourage oral fluid intake

2)repeat U&E's tomorrow

3) Stop oral ATB's

Surg Lt Code A

1/9/99 Patient c/o 1) Swollen ® leg

2) Distended abdo

o/e Dependent Oedema ® lower leg

° tenderness / redness / warmth to calf

Abdo distended - non - tender, large bladder

Plan 1) elevate ® leg

RESTRICTED

2) Intermittent urinary catheterisation

Surg Lt Code A

To clarify my entries relating to the patient Sheila GREGORY dob Code A

At this time in August 1999 I had just taken up my post as Senior House Officer in Orthopaedics at the Royal Hospital, Haslar.

Where I have written on page 83 of the medical notes

9/7 post ® DHS - This means it is 9 days since the patient Sheila GREGORY had a right Dynamic Hip Screw Operation.

Mobilising - This is self explanatory.

Awaiting transfer to GWMH- The patient has been accepted for ongoing care at the Gosport War memorial Hospital.

Temp 37.5 - The patient's temperature was slightly raised.

Plan As Above - This means I have referred to the recommendations of Dr Tandy (consultant in Elderly Medicine)she has recorded a request for Infection screening (Chest X-ray, Midstream Urine Test). Dr Tandy has also requested for a Thyroid Function test and to inform her when the stool sample result was available.

The plan that I have written is as follows;

CXR = Chest X-ray

MSU= Midstream Urine test - A urine sample was obtained for bacterial analysis.

FBC = Full Blood Count.

ESR = Erythrocyte sedimentation rate. This is a non specific inflammatory marker to determine any underlying infection.

TFT's = Thyroid Function Test. This was to determine the Thyroid function.

27/8/99

Hx noted = History noted which pertains to Dr West's entry on page 84 of the medical notes

RESTRICTED

dated 26/8/99.

Temp 37.5 Her temperature is slightly raised.

®= (right) *Leg swollen.* ° *calf tenderness* = (No calf tenderness) ° *warmth/tenderness* = (no warmth or tenderness) This is an indication that Deep Vein Thrombosis is clinically unlikely.

Plan

TED = Transdermal Embolic Deterrent stockings- These can be uncomfortable, they are used to prevent Deep Vein Thrombosis.

CT = (Continue) *low Molecular Weight Leparin* This is an anti Deep Vein Thrombosis medication.

Start Erythromycin This is an antibiotic

ROS over wk/end = Removal of sutures over the weekend.

27/8/99

No MSU = No Midstream Urine was sent. I have highlighted the fact that the Midstream Urine sample had not been done and needed to be.

TFT = Thyroid Function Test as recorded by Dr WEST on 25/8/99 showed a reduced free T3 thyroid hormone.

Hb = (Haemoglobin) *105*

Na+ = (Sodium) *134*

Creat = (Creatinine) *71*

WCC = White Cell Count *8.23*

K+ = Potassium *4.1*

PLT = Platelets *454*

Bicarb = Bicarbonate 29

These results are all normal.

ESR 12 = Erythyrocyte Sedimentation Rate. This is normal for a person who has just undergone surgery.

Urea 6.6 (↑)* = Urea is slightly elevated.

CXR = Chest X-ray as recorded by Dr WEST

Plan

RESTRICTED

1) Erythromycin started blindly to cover possible infection. This is self explanatory.

2)Repeat MSU. I am asking for another sample of urine to be sent for analysis.

3)Encourage Oral fluid intake. This is to prevent dehydration.

4)Discuss ↓ T3 with physician. I have then discussed the reduced Thyroid hormone levels with the Medical Registrar who has advised me that the thyroid function test (TFT) should be repeated in 4-6 weeks.

28/8/99 W/R Reg = This is a ward round with the Registrar.

No change - temp 37.0 There is no significant change in the patient's circumstance. The temperature of 37 is recorded as normal.

Plan as above. This means there are changes to be made to the previous plan of 27/8/99.

31/8/99 W/R Code A A ward round was conducted by Code A who was the Consultant in charge of the case. I have written the entries in the medical notes of behalf of Code A.

ROS- wound healing well. The sutures have been removed and the wound is healing well.

Mobilising slowly- awaiting bed at GWMH. This is self explanatory.

Temp37.5 This is slightly raised. *Otherwise well* No other significant issues apparent.

° *Cough* = No cough. *Chest clear.* Her chest was clear on examination with a stethoscope.

Plan 1)Encourage Oral fluid intake. This is to prevent dehydration.

2)Repeat Urea& Electrolytes tomorrow. This is to monitor the patient's blood biochemistry and kidney function as a routine post operative procedure.

3) Stop Oral ATB's. This means stop oral antibiotics i.e. Erythromycin.

1/9/99

Patient c/o 1) Swollen ® leg

2) Distended Abdo. This means that the patient has complained of a swollen right leg and distended abdomen. I have examined her leg and concluded that she has a dependent odaema which is the cause of her swelling. (The swelling is due to gravity and inactivity)

I have further recorded *No tenderness, redness or warmth to the calf.* This is suggesting DVT to be clinically unlikely.

RESTRICTED

On examination I have also recorded that the abdomen was distended. There was however no pain illicited whilst examining the abdomen. Her bladder was noted to be full suggesting Urinary retention.

Plan

1) Elevate ® leg. This is to assist in reducing the dependent odaema.

2) Intermittent urinary Catheterisation. This is self explanatory.

I had no further dealings with this patient. These notes indicate that during this period between 25/8/99 and 1/9/99 the patient Sheila GREGORY was making satisfactory progress

RESTRICTED

Form MG11(T)

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

Statement of: Code A

Age if under 18: O.18 (if over 18 insert 'over 18') Occupation: CLINICAL MANAGER

This statement (consisting of 5 page(s) each signed by me) is true to the best of my knowledge and belief and I make it knowing that, if it is tendered in evidence, I shall be liable to prosecution if I have wilfully stated anything which I know to be false or do not believe to be true.

Signed: Code A Date: 06/10/2005

I am presently employed by Coventry and Warwickshire Ambulance NHS Trust and have been since October 2003, as a Clinical Manager. I am in charge of all aspects of clinical care within the ambulance trust. I manage the day to day running of the ambulance service.

In 1996 I qualified as a registered nurse part 12 at The College of Nursing and Mid-Wifery at Staffordshire. I have since worked within Health Care both with the Royal Navy and the National Health Service.

I produce my C.V. as DM/1.

In 1999 I was employed as a nursing officer on E3 Ward at The Royal Hospital Haslar, Gosport . I was involved in the management of the clinical running of E3 an orthopaedic ward. I was supervised by the senior nursing officer on the ward who at that time was Captain JACKSON . The ward staff consisted of approximately 20 staff who were on a 24 hour rota. The ward had approximately 20 beds and it treated people with orthopaedic injuries, i.e. any type of boney injury. I left Royal Haslar Hospital in 2000.

I was in charge of the management of the ward whilst my staff would care and treat the patients. I would supervise the staff and help out on the ward with the patients care on occasions.

I have been asked to detail my involvement in the care and treatment of Sheila GREGORY . From memory and referral to entries in her medical notes, exhibit reference BJC/21 , I can say

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that I have no personal recollection of Mrs GREGORY, but from referral to pages 9 and 10 of her medical notes, I can state that Page 9 and 10 is a discharge letter/transfer written on 3-9-99 (03/09/1999) by myself , it reads:-

Mrs S. GREGORY

Code A

Hosp. No. N00180798

Dear Sister/Charge Nurse

Thankyou for accepting this 91 year old lady who was admitted on the 15.8.99 (15/08/1999) after a fall at home in which she sustained a fractured right neck of femur. This was surgically corrected on the 16.8.99 (16/08/1999) when a dynamic hip screw was applied. She mobilises with the assistance with one using a zimmer frame. She has an in dwelling catheter due to repeated incontinence, she is also incontinent of faecal matter. This lady also suffers from LVF, Hypertension Asthma and thyroid problems (Hypothyroidism). She is allergic to Penicillin and is on a number of medications.

BECLOFORTE (inhaler) 250 mcg BD.
IPRATROPIUM BRUMIDE (inhaler) 2 puffs QDS.
THYROXINE 100 mcg OD.
FERROUS SULPHATE 200 mg TDS.
PROCHLROAPERAZINE 5 mg BD.
SENNA 2 tablets OD
CO-DYDRAMOL 2 tablets PRN.
LACTULOSE 15 ml BD.

At times Mrs GREGORY becomes very confused to both time and place. If you have any further queries please contact Ward E3 on Ext 2127.

I have then signed the entry.

Signed: Code A

Signature Witnessed by:

RESTRICTED

SLT DM TOLLEY QARNNS

This letter is more or less self explanatory and gives the sister, nurse in charge of the ward that Mrs GREGORY is to be transferred to a brief outline of the patient's medical condition.

LVF is left ventricular failure, i.e. this is a form of heart failure, this is a deterioration of the muscle of the left ventricular in the heart primarily due to age.

Hypothyroidism is an under active thyroid i.e hormone secretions.

Hypertension is high blood pressure.

I have included that Mrs GREGORY was allergic to penicillin as this could be important in her future care.

I have then listed the drugs that Mrs GREGORY was discharged on.

BECLOFORTE and IPRATROPIUM BRUMIDE are inhalers for the treatment of her asthma.

THYROXINE is for her hypothyroidism.

FERROUS SULPHATE would have been for post operative anaemia, i.e. low blood count.

PROCHLROAPERAZINE is anti emetic, anti sickness tablet, this could have been prescribed as elderly people who have anaesthetics can suffer for long periods with vomiting and nausea.

SENNA and LACTULOSE are laxatives.

CO-DYDRAMOL is a form of analgesic paracetamol - codeine based. This was prescribed as 2 tablets when required by the patient.

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I have mentioned that Mrs GREGORY becomes very confused to both time and place, that would have been an observation from time of admission through to discharge by nursing staff.

Mrs GREGORY was being transferred for rehabilitation. I can say that she was not in constant pain as she was discharge from our care on PRN CO-DYDRAMOL, i.e. an as required painkiller. The aim would have been to rehabilitate her, and mobilise her sufficiently so that she could resume her normal daily life.

RESTRICTED

Form MG11(T)

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

Statement of: REID, RICHARD IAN

Age if under 18: over 18 (if over 18 insert 'over 18') Occupation: CONSULTANT GERIATRICIAN

This statement (consisting of 27 page(s) each signed by me) is true to the best of my knowledge and belief and I make it knowing that, if it is tendered in evidence, I shall be liable to prosecution if I have wilfully stated anything which I know to be false or do not believe to be true.

Signed: R. Ian Reid Date: 24/10/2005

I am Doctor Richard Ian REID MB, ChB. I reside at the address detailed overleaf. I qualified at Glasgow in 1974.

I became a Member of the Royal College of Physicians (United Kingdom) in 1978, a Fellow of the Royal College of Physicians and Surgeons of Glasgow in about 1988 and a Fellow of the Royal College of Physicians (London) in about 1990.

My General Medical Council registered number is Code A

Experience

1. House Officer (Medicine) at Royal Alexandra Infirmary, Paisley, Scotland from August 1974 to January 1975.

2. House Officer (Surgery) at Stirling Royal Infirmary, Stirling, Scotland from February 1975 to July 1975.

3. Senior House Officer (Obstetrics and Gynaecology) at Paisley Maternity Hospital, Paisley, Scotland from August 1975 to January 1976.

4. Senior House Officer (Geriatric Medicine) at the Victoria Geriatric Unit, Glasgow from February 1976 to July 1976.

Signature Witnessed by: Code A

5. Senior House Officer (Cardiology) at the Glasgow Royal Infirmary, Scotland from August 1976 to April 1977.

6. Registrar in General Medicine at the Kilmarnock Infirmary, Kilmarnock, Scotland from May 1977 to July 1979.

7. Senior Registrar in Geriatric Medicine at Portsmouth and Southampton Hospitals from August 1979 to July 1982.

8. Consultant in Geriatric Medicine at Southampton General Hospital from August 1982 to March 1998.

My current role which I began in April 1998, is as Consultant in Geriatric Medicine and Medical Director of East Hampshire Primary Care Trust (formally Fareham and Portsmouth Health Care Trust). I am based at the Queen Alexandra Hospital, Cosham.

I have a full time National Health Service contract which consists of 11 (eleven) programmed activities (PAs) per week. One programmed activity is 4 hours. I have an 'On Call' responsibility and work weekends (Saturday and Sunday on roughly one weekend in six basis).

I began the responsibility of looking after 'In Patients' at Gosport War Memorial Hospital in mid-February 1999.

This continued for a period of about 14 months unti about May 2000.

As Consultant to Gosport War Memorial Hospital I had a responsibility for the in patients on Dryad Ward of the hospital.

In this role I supervised the work of Doctor Jane BARTON , a local General Practitioner who, in addition to her work in general practice, worked as 'Clinical Assistant' at Gosport War Memorial Hospital.

In the absence of Dr BARTON I supervised the work of any 'locum' or partners at her general practice who covered her responsibilities for her.

It was also my role to supervise the work of any Specialist Registrar who was attached to me on Dryad Ward at Gosport War Memorial Hospital.

I undertook a weekly ward round of Dryad Ward which I usually conducted on Monday afternoons.

During the ward round I would visit each of the in patients on Dryad Ward.

I was accompanied on my ward round by the Clinical Assistant, Dr Jane BARTON, every two weeks, if she was available to do so.

I also provided consultant cover to Daedalus Ward, the other consultant led ward at the Gosport War Memorial Hospital, when my colleague Dr A LORD was on leave or unavailable. This was a reciprocal arrangement with Dr LORD who would normally cover my leave periods or unavailability. In the event of myself and Dr LORD being unavailable for long periods of time then locum consultant cover would be sought. However for short periods of absence then no locum cover was arranged. If the Clinical Assistant, Dr BARTON, was experiencing a particular problem regarding the management of a patient, then I would expect the Clinical Assistant to contact me to seek advice or to ask me to attend Dryad Ward to carry out an examination of the patient or see relatives who had concerns.

If my advice was sought by the Clinical Assistant then I would expect a note to be made on that patient's clinical notes by the Clinical Assistant. Dr Jane BARTON is a very experienced doctor and as such it would be a serious clinical problem relating to the treatment of a patient that would require her to seek such advice.

If a problem arose requiring a Consultant input during any short term unavailability of both

myself and Dr LORD then I would expect the Clinical Assistant to contact the Elderly Medicine Office at the Queen Alexandra Hospital, Portsmouth, to obtain the required consultant input.

The clinical notes of the patient are where a record is kept of the clinical treatment of a patient.

I would expect a note to be made on the clinical notes on a patient's admission to the hospital, giving a brief history and the results of any examination and treatment.

I would also expect a prescription sheet to be written up detailing any drugs prescribed on admission (see separate statement dated 04/10/2004).

The clinical notes of a patient would then be maintained by the Clinical Assistant or doctor covering that responsibility, myself as Consultant, with entries from other clinical staff when consulted regarding the management of a patient.

A nursing record is also commenced on admission of a patient and this is maintained by the nursing staff. During my ward round of Dryad Ward I would visit each patient, read their clinical notes, examine the prescription sheets and obtain additional information from the nursing staff, provided from the nursing records. This information is usually verbally provided and it would be unusual for me to read the nursing record of a patient.

This information together with information I have obtained myself as a result of any examination I have made of the patient, would form the basis of any note that I made on the patient's clinical notes.

If there were no marked change in the patient's condition, treatment or management then I would not expect any entry to be made on a patient's clinical notes by the Clinical Assistant.

However I would usually make a note on the clinical notes of every patient I saw during my ward round.

Included in my notes on the clinical notes would be any instructions regarding the clinical care of a patient to the Clinical Assistant.

In 1999 I was the Consultant Geriatrician in Elderly Medicine, part of my responsibilities included Dryad Ward at the Gosport War Memorial Hospital.

I have been asked to detail my involvement with the patient Sheila GREGORY , DoB 12/07/1908. I do not remember this patient or the subsequent treatment that was administered. I have been shown the medical records relating to the patient Sheila GREGORY, exhibit reference BJC/21 . I can confirm that I have written the following entries:

130999 (13/09/1999)
Leaning to L = (Left) whilst standing
Poor appetite
Confused but witty
Poor inhaler technique - try nebuliser
I REID

200999 (20/09/1999)
Managing nebuliser
V poor appetite
Mobilising 1 - 2 steps æ help of two persons
Check routine bloods
I REID

270999 (27/09/1999)
(1) Appetite sl - (slightly) improved
? Mood improving - continue Fluoxetine
(2) Generally less well, no obvious physical signs
(3) Catheterised
(4) Occ (occasional) faecal incontinence

RESTRICTED

I REID

041099 (04/10/1999)

Much better motivated .

Needs help of one person (occ 2) for most activities

Occ agitation needing Thioridizine (tranquilliser)

Still occ faecal incontinence

Still needs encouragement to eat and drink

I REID

On page 69 of the medical records I have written the following entries:

111099 (11/10/1999)

Still v. dependent

Delightfully (USU) = (usually) *confused!*

Needs nursing home placement

I REID

181099 (18/10/1999)

IC (= incontinent) *uniformed faeces withhold Lactulose pro.tem*

Refer for nursing home care

I REID

251099 (25/10/1999)

Can walk æ frame with persuasion ++

Needs 1-2 to transfer, dress, etc.

Catheterised

Only occ faecal incontinence

I REID

011199 (01/11/1999)

Episode of vomiting today - seems well now

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Still soft, mushy stools - ↓ (= reduce)

Mg (oh) 2 10mls b.d (Magnesium hydroxide) *Laxative*

I. REID

151199 (15/11/1999)

Less well

- chest infection

- frailer

- occ bouts of nausea

O/E (= on examination) *Apyrexial*

P (= pulse) - *84/min Reg - HS - loud*

V.S → axilla

°OED (= Oedema)

Continued present R (treatment)

Except Thioridizine to P.R.N.

I. REID

On page 70 of the medical records I have written the following entry:

Further decline

Comfortable

Opening eyes to speech - short verbal response

P - (= pulse) uncontrolled AF

RESP rate - 24/min

- chest clear at present

Stop Frusemide (Diuretic)

Continue Diamorphine

I. REID

Ward rounds at Dryad Ward consisted of myself together with the senior nurse in charge of the ward. This was normally the ward sister or in her absence a staff nurse. I was sometimes

accompanied by a specialist registrar. At this time it was Dr RAVINDRANE (the post of specialist registrar was a training post in elderly medicine).

On alternate weeks Dr BARTON would normally be present on the ward round. My ward rounds would be conducted on Monday afternoons. These would take between two and half to three hours to complete.

A ward round was conducted by seeing every patient on the ward. On average each patient would take eight to nine minutes to see. I would ask the nursing staff and Dr BARTON, if she was present, if there were any problems. If there were, where appropriate, I would examine the patient. I would then make decisions about the patient's management.

It was also usually my practice to view the prescription sheet and make any appropriate changes. It was normal practice to write my own entries in the notes, even when accompanied by other medical staff.

The reason that Dr BARTON only attended every fortnight was because my colleague, Dr Althea LORD, also conducted a ward round on a Monday afternoon on the Daedalus Ward in the Gosport War Memorial Hospital and was accompanied by Dr BARTON. To clarify this Dr BARTON accompanied me on ward rounds on alternate weeks.

It was my understanding that, other than when Dr BARTON was on holiday, she visited Dryad and Daedalus Ward daily in her capacity as Clinical Assistant. This was every morning Monday to Friday at 0730 hrs to review any patients identified by the nursing staff as having a medical problem. I also understand that she visited most, if not every, afternoon to check in new patients and review any other medical problems which may have arisen. I also understand that she would come in, in her own time to speak to relatives.

To clarify the entries that I have written in the medical notes commencing on page 67 of exhibit BJC/21 where I have written *Leaning to left whilst standing*, firstly I would have normally reviewed the previous entries in the medical notes. I note that on the 06/09/1999 that Dr

RAVINDRANE has recorded that the patient had a left sided facial droop. He has also recorded the results of a neurological examination which appeared to be otherwise normal.

In view of this I may have been looking for other neurological signs and have subsequently recorded that in my entries.

At this stage I would have been probably considering whether the patient might have had a very mild stroke.

Poor appetite - this is self explanatory.

Confused by witty - this probably means that Mrs GREGORY was not fully orientated in time and place and was providing amusing answers to my questions.

Poor inhaler technique - try nebuliser - this almost certainly reflects the fact that the nursing staff had told me that Mrs GREGORY found it difficult to co-ordinate the use of an inhaler and I suggested the use of a nebuliser. (This does not require manual dexterity).

290999 (29/09/1999) Managing nebuliser - this refers to the fact that the nursing staff had reported that using a nebuliser was successful.

V poor appetite - again this would have been reported by the nursing staff to me. Poor appetite can be due to physical or mental causes.

I would have noted from the prescription sheet (page 165/BJC/21) that the patient had been prescribed on the 07/09/99 Fluoxetine, 20 milligrams, once daily with the first dose being given from the 08/09/99.

Fluoxetine is an anti depressant (this drug is manufactured by a number of pharmaceutical companies, one of whom markets this drug under the name Prozac).

Variable confusion - this would have been reported to me by the nursing staff, but it may also have been my own observation.

Mobilising 1 - 2 steps æ help two persons - this may have been reported to me by the nursing staff but it was usually my practice to assess patients' walking for myself.

Check routine bloods - I have asked for this to be done because of the poor history of appetite and variable confusion. This was in order to exclude a physical cause for these symptoms. It is likely that these tests would have been done the following day and the results would have been available on the ward in the next two to three days. I would not see them until the following week.

Dr BARTON would see the results of the blood tests whenever they arrived on the ward, whether they were normal or abnormal. She would take whatever action was necessary.

270999 (27/09/1999)

(1) Appetite SL = slightly improved - this entry is self explanatory.

? mood improving - continue Fluoxetine - this would have been reported by the nursing staff and my question mark about whether the patient's mood was improving could have reflected both the views of the nursing staff and my own observations.

As anti depressants can take some weeks to be effective and as Mrs GREGORY had been on anti depressants for just under three weeks, I felt it would be important to continue the prescription of Fluoxetine.

(2) Generally less well - no obvious physical signs - this could have reflected both the observations of the nursing staff and my own observations.

It is likely that this also reflected the fact that physical examination had failed to reveal any abnormalities.

It is also likely that these observations included measurement of temperature, pulse, blood pressure and respiratory rate.

(3) Catheterised - this indicates the presence of a drainage tube in the bladder.

(4) Occ faecal incontinence - this means occasional loss of control of bowels and this would have almost certainly been reported to me by the nursing staff.

041099 (04/10/1999)

Much better motivated - this statement reflects the fact that poor motivation can be a symptom of depression and implies that the improved motivation could well be due to the prescription of Fluoxetine.

Needs help of one person (occ 2) for most activities - This is self explanatory in that the patient's acts of daily living - washing, dressing and toileting required the help of one, or occasionally two, persons.

Occ agitation needing Thioridizine - this agitation would have been reported to me by the nursing staff. I would have also observed from the prescription sheet that Mrs GREGORY has been prescribed Thioridizine which is a tranquilliser. The does was 10 milligrams which was to be administered on a PRN (= as required) basis.

This is the lowest dose which is normally prescribed and was appropriate. This drug was first administered on 01/10/1999.

Still occ faecal incontinence - this again would have been reported to me by the nursing staff. This is not an uncommon problem in elderly patients who are confused.

Still needs encouragement to eat and drink - this would have been reported to me by the nursing staff.

111099 (11/10/1999) Still very dependent - this would have been reported to me by the nursing

staff.

Delightfully (usually) confused - this statement would have been made as a result of my own observations as well as those of the nursing staff.

Needs nursing home placement - this statement reflects my view that further attempts to rehabilitate Mrs GREGORY to a level where she would be able to manage again at home were not going to be successful and that because of her level of dependency she would need care in a nursing home rather than a residential home. At this stage I felt that Mrs GREGORY should be considered for a nursing home for continuing care.

181099 (18/10/1999) I/C (= incontinent) unformed faeces withhold Lactulose protein - this would have been reported to me by the nursing staff and it means that Mrs GREGORY was losing control of her bowels and that her bowel motions were of a soft porridge-like consistency. This can be caused by Lactulose and hence my instruction to withhold it for the time being.

The prescription and administration of Lactulose would have been appropriate until this stage, if her bowel motions had been formed until this time.

Refer for nursing home care - Mrs GREGORY was on the Dryad Ward for rehabilitation. It reflects that I no longer felt that rehabilitation to her home address would be successful and that a move should now take place to transfer Mrs GREGORY to a nursing home.

This would normally be done by discussing with the family and by making a referral to Social Services. Nursing staff would normally make a referral to Social Services for assessment and placement in a nursing home.

251099(25/10/1999) Can walk with frame with persuasion ++ - this means Mrs GREGORY was physically able to walk with the aid of a walking frame but that she was extremely reluctant to do so (++ = very reluctant).

RESTRICTED

Needs one to two to transfer, dress etc - this would have been reported to me by the nursing staff and confirms that there had been no improvement in these activities. The referral for nursing home care continued to be appropriate.

Catherised - this is self explanatory.

Only occ faecal incontinence - this is self explanatory. This would again confirm that nursing home rather than residential home care would be appropriate.

011199 (01/11/1999) Episode of vomiting today - seems well now - this would have been reported to me by the nursing staff, and is self explanatory.

Still soft mushy stools - ↓ Mg (OH) 2 10 mls bd - this would have been reported by the nursing staff and because of this I had taken the decision to reduce the dose of Magnesium hydroxide which is a laxative. It had been initially prescribed at 20 mls bd which is twice daily. It was reduced because of the soft stools.

From examining the prescription sheet it does not appear that Mrs GREGORY ever received any magnesium hydroxide. This is probably because it is normal practice to allow nursing staff to use their discretion in respect of the administration of laxatives and anti diarrhoeal drugs according to how the patient's bowels are reacting.

On page 136 of the medical notes Loperamide has been prescribed, this is a drug used to control loose stools and diarrhoea. It was written up on 18/10/1999 first administered on 29/10/1999 @ 1150 hours; it was also administered on the 01/11/1999 @ 0715 hours.

151199 (15/11/1999) Less well, chest infection, frailer, occ bouts of nausea - this would have been reported to me by the nursing staff and may have also been as a result of my own observations.

O/E (= on examination) *Apyrexial, P-84/min reg HS - loud VS →axilla - neck.*

°OED (= no oedema), *chest clear, legs* √√ - this reflects the results of my examination which revealed that Mrs GREGORY's pulse was 84 beats per minute and regular. This is a normal pulse rate. It also indicates that I have listened to her heart and that this revealed a loud systolic murmur which radiated to both the axilla and to the neck. To clarify this entry, a murmur is a sound which is due to turbulent flow of blood through a valve in the heart. The term "systolic" refers to its timing in relation to each cycle of contraction of the heart muscle. In Mrs GREGORY's case I thought it possible that the cause of this condition was either narrowing of the aortic valve or a leaking mitral valve or a combination of both.

This murmur had previously been noted. Her records show that she had this murmur from at least 1995.

°OED - no oedema means that there was no swelling of Mrs GREGORY's legs.

Chest clear - means that on listening to Mrs GREGORY's chest and lungs I was unable to detect any abnormality.

These findings in total mean that Mrs GREGORY did not have any new problem with her heart or lungs and there was no evidence of heart failure or a chest infection.

Legs √√ - this refers to the fact there was no swelling of her legs or evidence of thrombosis.

Continue present R (= continue present treatment), except change Thioridazine to PRN - this means that I felt that there was no need to change any of Mrs GREGORY's treatment other than reducing the regular dose of tranquilliser to receiving it only on 'as required' basis.

Mrs GREGORY was prescribed Thioridazine 10 milligrams twice daily on a regular basis commencing 07/10/1999.

RESTRICTED

Further decline - this statement is likely to have been made in relation to report from the nursing staff and from Dr BARTON's notes on the 18/11/1999. I have noted that Dr BARTON has recorded

further deterioration in general conditions
start oral opiates in a small dose
please make comfortable
I will speak to granddaughter
I am happy for nursing staff to confirm death
? further CVA?

This suggests to me that on 18/11/1999 Dr BARTON felt that Mrs GREGORY was terminally ill that she might have sustained a further stroke - Cerebro vascular accident (CVA) and that the overriding priority was to keep Mrs GREGORY comfortable.

Where I have shown *further decline* this probably means that Mrs GREGORY had deteriorated more since being seen by Dr BARTON on 18/11/1999.

Comfortable - this means that Mrs GREGORY appeared to me to be peaceful and not in any pain or distress.

Opening eyes to speech - short verbal response - this reflects my attempt to access Mrs GREGORY's conscious level.

P (= pulse) *uncontrolled AF,* (= atrial fibrillation) - this means a rapid irregular rhythm of the heart. It would appear from her records that Mrs GREGORY has intermittently had this problem in the past. This condition can cause patients to become unwell but it can also develop when patients become unwell from another cause.

Resp rate - 24/per min.

RESTRICTED

Chest clear at present - this means that when I examined Mrs GREGORY her breathing rate was 24 breaths per minute. This is higher than normal and could be an early sign of a chest infection or pneumonia developing. However on listening to Mrs GREGORY's chest there was nothing abnormal to be found at that time.

Stop Frusemide - Frusemide is a diuretic which are drugs used in the treatment of heart failure when fluid starts to accumulate in the body (normally in the legs or lungs or both).

However as I have recorded that Mrs GREGORY was only opening her eyes to speech it is highly likely that at this time Mrs GREGORY would have ceased to eat and drink.

Continuing Frusemide would have meant that she was at increased risk of dehydration, hence my decision to stop the Frusemide.

Continue Diamorphine - I have written this instruction because Mrs GREGORY appeared to be very comfortable on the present dose of Diamorphine without being over sedated.

Overall although I cannot remember Mrs GREGORY I feel that it is likely that at this stage I felt that she was dying.

I have been asked to comment on why there is a break in the medical records commencing from page 67 (BJC/21) of seven day intervals.

The reason there is a break of seven days in the medical records is that consultant ward rounds are conducted on a weekly basis. The previous entry on the 06/09/1999 which was conducted by Dr RAVINDRANE (at that time in September 1999 Dr RAVINDRANE was the senior registrar in elderly medicine and he usually accompanied me on my weekly ward rounds).

The fact that the entry for 06/09/1999 was written by Dr RAVINDRANE was probably due to the fact that I was on holiday.

Ward rounds would normally consist of Dr RAVINDRANE and myself together with the senior nurse in charge that day and on alternate weeks, Dr BARTON.

A ward round consisted of seeing each patient and making an assessment of the patient. A record of the assessment is then made in the notes. The reason for recording this informed assessment is to ensure continuity of care. It is my normal practice to record any change in medication. Any change in medication that I indicated could be written up by Dr BARTON, Dr RAVINDRANE or myself.

The prescription sheets have six sections with the following purposes:

Page 1 is a cover page with general information.
Page 2 is for once only and as required drugs (PRN).
Page 3 is for regular drugs.
Page 4 is for regular drugs.
Page 5 is for daily review prescriptions.
Page 6 is titled "For Nursing Use Only - Exceptions to Prescribed Orders".

To clarify the prescription sheets as laid out within the medical records of exhibit BJC/21 the following may assist for the date 03/09/1999:

Page 153 of the medical records = Page 1 of the prescription sheet.
Page 154 of the medical records = Page 2 of the prescription sheet.
Pages 155, 157, 159 of the medical records = Page 3 of the prescription sheet.
Pages 161, 163, 165 of the medical records = Page 4 of the prescription sheet.
Page 166 of the medical records = Page 5 of the prescription sheet.
Page 160 of the medical records = Page 6 of the prescription sheet.

In relation to the prescription sheets for the 07/10/1999.

Page 135 of the medical records = Page 1 of the prescription sheet.

RESTRICTED

Page 136 of the medical records = Page 2 of the prescription sheet.
Page 137, 139, 141 and 143 of the medical records = Page 3 of the prescription sheet.
Page 145, 147, 149 and 151 of the medical records = Page 4 of the prescription sheet.
Page 152 of the medical records = Page 5 of the prescription sheet.
Page 144 of the medical records = Page 6 of the prescription sheet.

In relation to the prescription sheets dated 18/11/1999.

Page 183 of the medical records = Page 1 of the prescription sheet.
Page 184 of the medical records = Page 2 of the prescription sheet.
Page 186 of the medical records = Page 3 of the prescription sheet.
Page 188 of the medical records = Page 4 of the prescription sheet.
Page 187 of the medical records = Page 5 of the prescription sheet.
Page 185 of the medical records = Page 6 of the prescription sheet.

I have read the entry written by Dr BARTON on 03/09/1999 on page 66 of the medical record which relates to the admission of Mrs GREGORY when she was transferred to Dryad Ward from Haslar Hospital. The entry gives a brief summary of Mrs GREGORY's medical problems and functional status.

I have been asked to comment about the last line of the entry which reads as follows:

I am happy for nursing staff to confirm death.

It would only be normal practice to make such a statement if it was felt that the patient was close to death.

It would appear to be at variance to previous entries which refer to *gentle rehab ? nursing home.* If Dr BARTON felt at this stage that this lady was medically stable, had rehabilitation potential, this was an inappropriate statement to make. I cannot recollect whether I noted this statement or whether I discussed this statement with Dr BARTON.

On 13/09/1999 which is when I conducted my ward round from referring to my entry in the notes, I feel that it was unlikely that death was imminent. However I note that Mrs GREGORY was 90 years old and the fact that Dr BARTON had suggested *gentle rehabilitation* would suggest to me that Dr BARTON felt that this very elderly lady was physically frail.

I have been asked to comment on the drugs prescription chart which were written on 03/09/1999, page 159 of exhibit BJC/21 refers. This prescription sheet is divided into drugs which are to be regularly administered and those to be given as required (PRN). It would be my normal practice to review all the drugs which are being prescribed regularly and to note the frequency of the administration of the "as required drugs". The following drugs have been prescribed, to be given on a regular basis, by Dr BARTON on the 03/09/1999:

Thyroxine 100 mcgs once daily - Thyroxine is used in the treatment of an under active thyroid gland. This is highly likely to be an appropriate dose and this was confirmed by a blood test taken on 21/09/1999 which showed that the levels of thyroid hormone in the blood stream was adequate.

Ferrous sulphate in a dose of 200 mgs, three times daily - This is an iron supplement used in the treatment of iron deficiency anaemia. This is an appropriate dose. This drug continued to be administered until 29/09/1999, after which it was stopped.

I note that a blood test taken on 21/09/1999 showed that Mrs GREGORY was no longer anaemic and it is likely that when this information became available, Dr BARTON stopped its prescription.

Lactulose 15 mls twice daily - this is a laxative and this is an appropriate dose. This was commenced on 03/09/1999. She received this regularly until 14/10/1999. Between 15 - 18th October some doses were withheld. Between 19th - 23rd October no Lactulose was administered. Further doses were given on 24th and 25th of October, after which the prescription was crossed off. This is normal practice if a drug is no longer required.

Senna tablets, two to be taken night - Senna is a laxative used for the treatment of constipation, this was commenced on 03/09/1999. Mrs GREGORY received the Senna tablets fairly regularly until 14/10/1999 after which it appears she was not given anymore. (Lactulose softens the stools. Senna assists bowel mobility).

Atrovent inhaler, two puffs, 4 times daily - Atrovent is used in the treatment of asthma and wheeziness. It is likely that Mrs GREGORY had been taking this for some time as it was prescribed on admission. This dose is entirely appropriate.

Becloforte inhaler, 1 puff, twice daily - this is a steroid and is used to prevent attack of asthma and wheeziness. The dose is entirely appropriate and it is likely Mrs GREGORY had been on this drug for some time.

On pages 161, 163 and 165 of the medical records the following drugs were prescribed on 06/09/1999:

Paracetamol elixir 500? 1 gm QDS (= 4 x daily). This commenced on the 06/09/1999 and was administered daily until 07/10/1999 when the prescription was re-written as recorded on page 143.

Aspirin 75 mg 1 daily. This was prescribed by Dr RAVINDRANE on 06/09/1999 and administered from 07/09/1999 until 06/10/1999 when the prescription chart was re-written.

Fluoxetine 20 mg 1 daily. This was prescribed by Dr BARTON 07/09/1999 and administered from 08/09/1999 until 06/10/1999 when it was re-written as recorded on page 143 of the medical records.

Daktacort cr (= cream). To be administered twice daily to skin. This was prescribed by Dr BARTON on 13/09/1999 and was administered until 17/09/1999. This cream is used in the treatment of dermatitis, eczema and itching.

RESTRICTED

Ipratropium nebuliser (normal). (This is the same as Atrovent). This was prescribed by me in a dose of 200 mcg by inhaler form twice daily commencing on 13/09/1999 and this continued to be administered fairly regularly until 06/10/1999.

Budesonide nebuliser 250 mcgs by inhalation twice daily. This was prescribed by me. I presume this was prescribed on 13/09/1999 and was administered from 14/09/1999 until 04/10/1999. This drug is designed to prevent attacks of wheeziness and asthma.

On page 154 of the medical records on 03/09/1999 the following drugs were prescribed on as required basis (PRN):

Co-dydramol 2 tablets up to 4 times daily - this is a simple pain killer and given that Mrs GREGORY had recently had a fractured hip repaired and as it was planned to rehabilitate Mrs GREGORY, I feel that it was appropriate to prescribe this in case she suffered from pain on attempting to mobilise. This is an appropriate dose.

Prochlorperazine 5 mgs, 3 times daily - this is an anti nausea drug which was probably prescribed as co-drydamol can sometimes cause nausea and vomiting. I feel that it was reasonable to prescribe this drug. The dose prescribed was appropriate.

Oramorph 10 mgs in 5 mls - this is an opiate drug which is a strong painkiller. The dose prescribed was 2.5 - 5 mls to be taken up to four hourly. This is administered orally. 2.5 - 5 mls means that the dose prescribed was 5 - 10 mgs. This is an appropriate dose for a patient in severe pain or distress. There is no record that Mrs GREGORY was in any pain or distress and I feel that this prescription was inappropriate at this stage on Mrs GREGORY's admission in the absence of any documented pain.

Zopiclone 3.75 mls, mgs 1 at night - this is a sleeping tablet, I feel that its prescription and dosage on an as required basis was entirely appropriate.

RESTRICTED

On page 166 of the medical records there is the daily review prescription sheet. This section of the prescription sheet is infrequently used and was on the reverse of the prescription sheet used at that time. The circumstances in which this section is used is when a prescribed drug needs daily review, usually to titrate the dose of drug according to a patient's condition or the results of investigations. The following drugs have been prescribed on 03/09/1999:

Diamorphine 20-200 milligrams to be given subcutaneously over 24 hrs on an as required basis - Diamorphine is an opiate (a strong painkiller). The prescription was that this drug would be administered by a syringe driver .

Hyoscine 200-800 micrograms to be given subcutaneously over 24 hrs via a syringe driver - this drug is used to dry up oral secretions.

Midazolam 20-80 mgs to be administrated subcutaneously via syringe driver over 24 hrs - this drug is a sedative and is used to relieve distress.

I feel it was inappropriate to prescribe these drugs at this stage in the absence of any documented pain or distress and in the absence of any documentation that Mrs GREGORY was terminal ill.

This is not normal practice both in respect of the prescription of these drugs at this stage and the dosage ranges.

It is my usual practice to review every patient's drug chart on a ward round. However because this section is on the reverse and is infrequently used, I do not remember noticing the prescription of these drugs. I did not have a conversation with Dr BARTON about this particular prescription.

I do remember having one conversation with Dr BARTON about a variable dose prescription of Diamorphine in relation to one particular patient whom I cannot identify nor when this took place. I believe Sister HAMBLIN was present. As I remember this was prescribed for a

patient who was in pain and its prescription was, I felt, appropriate. My concern was about the range of dosage. I got the impression Dr BARTON was not happy about being challenged about her practice.

Dr BARTON told me that the reasons she did this. Firstly she was a full time GP and Chair of the Gosport Primary Care Group . She was not always immediately available and therefore was concerned that if a patient should develop severe pain or distress, nursing staff would be able to administer appropriate medication to the patient in a timely way as there could be a delay of some hours before she could attend to the patient.

Dr BARTON also told me that she was assisted in covering the wards when she was not available eg, when on holiday, by the other partners in her general practice. She told me that some of her partners were reluctant to attend the hospital when called by the nursing staff and that again the prescription of these drugs allowed the nursing staff to relieve pain and suffering without delay.

As far as I can recollect Sister Gill HAMBLIN was present when I had this discussion with Dr BARTON. Gill HAMBLIN confirmed that some of Dr BARTON's partners from the practice were reluctant to attend. I also remember hearing informally from other members of staff that some of Dr BARTON's partners were reluctant to attend the hospital. I do not remember specific names being mentioned.

I had been working in the Gosport War Memorial Hospital Dryad Ward for just a few months. Previously I had worked at Moorgreen Hospital in Southampton where we had a full time clinical assistant present Monday to Friday 9.00am (0900) to 5.00pm (1700) and therefore it was easy to respond to changes in patient's conditions. I had not worked before in a hospital where the day to day cover was provided by a full time GP working as a part time clinical assistant.

Although I was unhappy with this I accepted her explanation having been made aware of the difficulties she was experiencing in her General Practice. I trusted Dr BARTON because she

was an experienced GP, she was highly regarded locally and she was trusted and respected by the nursing staff. She always responded to their needs for help and support.

Also I believe Dr BARTON had been working in the Gosport War Memorial Hospital for eleven years prior to 1999. I had been working there at that time for six months.

I know that all of my colleagues who had worked there, before me, with Dr BARTON in the GWMH had great respect for her. There had been no complaints from the patients, relatives or the nursing staff that I am aware of in the eleven years that she had been working there. In view of this, I would not expect to offer the same level of supervision to Dr BARTON as I would to a trainee doctor.

I also trusted the nursing staff in using their discretion appropriately, in relation to the use of opiates and I do not recollect anything other than the minimum dose initially being administered to patients.

As far as I can ascertain these drugs mentioned so far were all prescribed to Sheila GREGORY on admission/day of transfer on 03/09/1999. I would add that I may not have noticed the Oramorph prescribed on the 03/09/1999 recorded on page 165 of the medical notes (BJC/21). I see from the prescription chart that none had been administered by the 13/09/1999 which is the first time that I saw this patient.

On page 143 of the medical notes, which is the prescription sheet, the following drugs were prescribed:

The first regular drugs prescribed commenced 07/10/1999.

Thyroxine 100 mcgs 1 daily was prescribed by Dr BARTON. This prescription continued until at least 15/11/1999. This is a continuation of the Regular drugs prescribed on 03/09/1999 (page 159 of the medical notes refer).

Lactulose 15 mls bd. This is a continuation of drugs prescribed on 03/09/1999 (page 159 of the medical records refer).

Senna Tabs 2 once daily. This is a laxative. This is a continuation of the prescription sheet of the 03/09/1999 as recorded on page 159 of the medical records.

Fluoxetine elixir 20 mgs in 5 mls. This was prescribed on 07/10/1999. It is an anti depressant and was administered once daily as per prescription from 07/10/1999 until 17/11/1999. This is an appropriate dose.

Dispersible aspirin 75 mgs 1 daily. This is frequently used for the prevention of stroke and/or heart attacks. This continued to be prescribed until 03/11/1999. Dispersible aspirin is used because it thins the blood. This was originally prescribed by Dr RAVINDRANE on 06/09/1999. Dr BARTON has continued this prescription quite appropriately.

Paracetamol elixir 250 mgs per 5 mls, 1 Gm QDS (= 4 x a day). To the side of this entry is written PRN. It appears that it was administered regularly until 21/10/1999 after which it was only occasionally administered. This is an entirely appropriate dosage. Paracetamol is a mild painkiller.

On page 151 of the medical notes the following drugs have been prescribed by Dr BARTON:

Thioridazine 10 mg twice daily. This was prescribed by Dr BARTON and commenced on the 07/10/1999. This was administered until the 31/10/1999. In relation to this entry I cannot explain why there is a line crossing out the 1800 entries from 23/10/1999 until 31/10/1999.

Thioridazine continued to be administered in mornings only at 1000 until at least 03/11/1999. Thioridazine is a tranquilliser and is used in the management of patients who are distressed or agitated. This is an appropriate dose which reflects my note of 04/10/1999 as recorded on page 68 of the medical records. The drug was changed on the 07/10/1999 from PRN (as required) to twice daily. This is likely to reflect the fact that the patient was becoming increasingly agitated.

This prescription has been crossed out after 14/11/1999, I am unable to state the reason why. I note that I requested this prescription to be stopped on 15/11/1999 during my ward round.

Temazepam 10 mg 1 at night. This is a sleeping tablet. This is an appropriate dose. The presumption would be that Mrs GREGORY was having difficulty sleeping. It was first prescribed 07/10/1999 and was continued until at least 15/11/1999.

Magnesium hydroxide 20 mls bd (= twice daily) was prescribed on 27/10/1999 and administered until 01/11/1999 when the prescription was crossed out and the dose reduced to 10 mls twice daily. It is a laxative used in the treatment of constipation. This amended prescription was continued until at least 15/11/1999.

Cefaclor 250 mg per 5 mls, 5 mls 3 x daily for 5 days. This is an anti-biotic and it was prescribed on 01/11/1999 and continued until 06/11/1999. It is commonly used in the treatment of urinary tract infections and chest infections. There is no entry as to why this prescription was made. This dose of Cefaclor is an appropriate dose and it is good practice to prescribe anti-biotics for a limited time eg 5 days.

On the same prescription sheet following from page 151 of the medical records recorded on page 136 of the medical records the following "as required" prescriptions have been entered:

Gaviscon liquid 10 mls PRN. This was prescribed by Dr BARTON on 08/10/1999. Gaviscon is used in the treatment of wind and indigestion and was administered once only on the 23/10/1999.

Oramorph 10 mg, 2.5 mls. This was prescribed in a dose of 2.5 - 5 mls four hourly by Dr BARTON on 08/10/1999 and 5 mg (2.5 mls) administered once at 2020 on 17/11/1999. This is a small and appropriate dose for a patient in pain or distress; however there is no record in the medical notes. Therefore I cannot say whether this was appropriate. It is not normal practice to prescribe Oramorph in the absence of documented pain or distress.

Metoclopramide 10 mg, oral or intra-muscular. This was prescribed by Dr BARTON on 11/10/1999. This was recorded as a verbal order given by Dr BARTON. This was administered once only at 1615 on 01/11/1999. The entry written on the medical notes on page 69 by me indicates that Mrs GREGORY had an episode of vomiting that day. This is an appropriate dose.

Loperamide 2 mgs 2 tablets QDS (= 4 times daily). Loperamide is an anti diarrhoeal tablet and was prescribed on 18/10/1999, and was administered on two occasions. On the 20/10/1999 @ 1150 and then on 01/11/1999 @ 0715. This is an appropriate dose for a patient with diarrhoea.

The following drugs have been prescribed in the daily review prescription sheet on page 152 of the medical records (P5): I note at the top of the page "regular" has been crossed off and PRN has been written in its place. I do not know who crossed this out.

Diamorphine 20-80 mg S/C in 24 hours. This was prescribed by Dr BARTON on 11/11/1999.

Hyoscine 200-800 mcgs S/C in 24 hours. This was prescribed by Dr BARTON on 11/11/1999.

Midazolam 20-80 mg S/C in 24 hours. This was prescribed by Dr BARTON on 11/11/1999.

Cyclazine 50-100 ? or 200 mg S/C in 24 hours. This was prescribed by Dr BARTON on 11/11/1999.

This is not an appropriate prescription in the absence of any note in the medical records demonstrating an indication for the prescription of these drugs.

There is no record that Dr BARTON conducted a ward round or made a record in the clinical records.

On page 186 of the medical records on the 18/11/1999 Dr BARTON prescribed the following drugs on a regular basis. The page is headed "Regular Prescription".

RESTRICTED

Thyroxine 100 mcgs once daily. This was administered from 15/11/1999 until 21/11/1999. This prescription has been crossed out; there is no record in the medical notes as to why this was done.

Fluoxetine elixir 20 mg per 5 mls (one teaspoon daily). This was administered from 18/11/1999 to 21/11/1999. The prescription has been crossed out and there is no record in the clinical notes to explain why.

Oramorph 10 mgs per 5 mls, 2.5 mls four hourly. (However the administration times record four times daily). This commenced on 18/11/1999. No further doses were given after 1000 on 20/11/1999.

There is a further prescription of *Oramorph 10 mgs in 5 mls*, 5 mls to be given at night. This was given on 18/11/1999 and the 19/11/1999. These are appropriate doses for a patient in pain and/or distress.

Both Oramorph prescriptions were crossed out (i.e. ceased to be given at the same time). There is no record in the notes as to why this was done.

Magnesium hydroxide 10 mls twice daily. This was given from 18/11/1999 to 21/11/1999. This prescription has also been crossed out.

Frusemide 40 mgs daily. This was prescribed on 20/11/1999 and was given on 20/11/1999 and 21/11/1999. I also note that this drug in the same dose was given on 19/11/1999 by intra muscular injection at 1530. This was a verbal message recorded by Sister HAMBLIN and has been countersigned by Dr BARTON. Frusemide is a diuretic which is used in the treatment of heart failure. This is appropriate management for a patient in heart failure. However it is not normally given intra muscularly but in the absence of a doctor on site (i.e. within the hospital) this could be appropriate to relieve shortness of breath due to heart failure, if a patient were very distressed.

On page 184 of the medical records the following entries have been recorded by Dr BARTON:

Diamorphine 20-80 mgs S/C (= subcutaneously) in 24 hours. This was prescribed by Dr BARTON on 18/11/1999 and 20 mgs was administered from 1700 on 20/11/1999. This was repeated at 1705 hours on 21/11/1999. I feel that it may well have been appropriate to prescribe this subcutaneously as Mrs GREGORY had been requiring regular Oramorph over the previous 48 hours. The starting dose administered was appropriate but the range prescribed was unusually large.

Hyoscine 200-800 mcgs S/C in 24 hours. This was prescribed by Dr BARTON on 18/11/1999 but was never administered.

It is often common in the terminal stages of life for secretions to gather in the upper airways and for patients to become distressed by being unable to clear these secretions.

I feel to prescribe this on an as required basis was acceptable medical practice. It would be more usual practice to prescribe a slightly more limited dosage range. However I must point out I am not an expert in palliative care.

Midazolam 20-80 mgs S/C in 24 hours. This was prescribed by Dr BARTON on 18/11/1999. It was not administered. Midazolam is a sedative which is commonly used in the treatment of distress and anxiety in patients who are terminally ill. The prescription of a single as required (PRN) dose of Midazolam would have been more appropriate to assess its effect before writing up a dosage range.

Cyclizine 50-200 mgs S/C in 24 hours. This was prescribed by Dr BARTON on 18/11/1999. Cyclizine is used to prevent nausea and vomiting which can be associated with the administration of Diamorphine. I am not an expert in palliative care but I feel that the starting dose was appropriate and the dosage range was probably reasonable. Cyclizine was first administered in a dose of 50 mgs over 24 hours at 1315 hours on 20/11/1999. It appears that

another dose of 50 mgs over 24 hours was started at 1700 hours the same day. I would suspect that this is because the Diamorphine infusion was changed at the same time i.e. 1700. A further infusion of Cyclizine was started at 1705 on 21/11/1999.

It is worth clarifying in respect of elderly patients, particularly confused elderly patients, that it can be extremely difficult to determine whether their distress is due to physical pain or mental stress or a combination of both. In this situation the prescription of opiates and a sedative can be entirely appropriate.

I have been asked to comment on the Wessex Guidelines For Palliative Care. To the best of my recollection I was unaware of the existence of the Wessex Guidelines until approximately 2001. I would like to stress again that I am not an expert in palliative care.

When I took over as consultant for Dryad Ward at the Gosport War Memorial Hospital in February 1999 there were no guidelines/protocols that I was aware of for the use of opiates and sedatives. At this time in 1999 Dr BARTON had been working as a clinical assistant for some eleven years and almost certainly had more hands on experience in palliative care, than I had. I was pleased to be able to rely on her considerable experience.

In 1999 the Wessex Guidelines, I believe, was a yellow book, which I first became aware of in 2001.

On page 165 of the prescription sheet I have prescribed Ipratropium Nebuliser (Atrovent is the trade name for Ipratropium), which commenced on the 13/09/1999. I also prescribed Budesonide to be administered by nebuliser and this started on 13/09/1999. This was prescribed because Mrs GREGORY had difficulty in using an inhaler.

I have checked the prescription sheets and to the best of my knowledge none of the drugs prescribed is penicillin based although I believe that the pharmacology of Cefaclor is similar. However I am not an expert in this field.

I am not able to state why the allergy to penicillin was not recorded in the 'drugs sensitivities' box. This is normally written up by the doctor completing the first prescription chart.

I can recall one instance where I discontinued the prescription of Diamorphine to an elderly lady on Dryad Ward. This patient had developed heart failure several days before I saw her on my ward round. As I remember this patient was prescribed it appropriately as she had been acutely short of breath. I discontinued it as she had improved and no longer required it.

As far as I can recollect this patient had had a stroke and had been visiting her daughter locally. I believe she originated from Kent. I do not remember any other instances where I have stopped or changed the prescription of Diamorphine.

The initial objective relating to Sheila GREGORY, who had suffered a fracture to her hip prior to being admitted to Dryad Ward of Gosport War Memorial Hospital on 03/09/1999, was to assess her physical and mental state and her rehabilitation potential.

It would appear from referring to the medical records that our initial aim was to remobilise this patient with a view to her returning home. From the records I think it is clear, after a period of attempting to remobilise her, that she would not be capable of returning home and would require placement in a nursing home.

It would appear that this was still the aim, at least until 01/11/1999, when it is recorded by me that the patient had an episode of vomiting. I have also recorded that the patient seemed well when I saw her on my ward round. It is possible that the episode of vomiting was related to a presumed urinary tract infection for which Cefaclor was prescribe that day.

On page 151 of the medical records Cefaclor, which is an antibiotic, was prescribed by Dr BARTON to this patient.

I next saw Mrs GREGORY on 15/11/1999. I have recorded that *(she was less well and that she had a chest infection, was frailer and was having occasional bouts of nausea).* I examined the

patient on 15/11/1999 and noted she had a normal pulse rate, that she had no ankle oedema and that she had a heart murmur. I also recorded that her chest was clear on using a stethoscope to listen to the chest (Auscultation). I have also recorded *legs* √√. This means that I have examined her legs for evidence of thrombosis and found none. I have recorded that her current treatment should be continued with the exception of changing Thioridazine to PRN (as required). I almost certainly did this because Mrs GREGORY was no longer agitated and was not in need of regular sedation.

I think that my note of her being frailer implies that there has been a significant deterioration in Mrs GREGORY's condition and that my examination confirmed that there was no obvious remediable cause for this.

I have recorded that Mrs GREGORY had a chest infection. The fact that I also recorded her chest to be clear means that this was likely to have been a minor infection of the upper airways, for which I judged antibiotics not to be necessary.

My next entry of the 22/11/1999 records that the patient has *further declined but was comfortable.*

I have also recorded that the patient was opening her eyes to speech and making a short verbal response.

The notes also record that I had found her to be in uncontrolled atrial fibrillation and that her respiratory rate was 24 per minute which is higher than normal.

I have also recorded that her chest was clear at the time.

This could be consistent with early broncho pneumonia to which elderly patients can rapidly, within a few hours, succumb.

I have been shown a copy of the death certificate which records the cause of death as la bronco

RESTRICTED

pneumonia, which is the primary cause of death. The death was certified by Dr BARTON.

Only one doctor is required to complete a death certificate for patients who are buried. No further medical certificates are required.

In the case of cremation, a second medical certificate has to be completed by one doctor (often the doctor who has signed the death certificate) and countersigned by a second doctor.

There is no specific record within the medical notes referring to broncho pneumonia; however these findings could be consistent with the onset of early broncho pneumonia, to which elderly patients can rapidly succumb, i.e. within a few hours.

I have been asked to comment about the lack of entries made by Dr BARTON.

I did not speak to Dr BARTON with reference to the lack of entries by her in the medical records.

The first reason is that by the time, i.e., in November 1999, I was aware that Dr BARTON was under considerable pressure because of her general workload with her GP practice commitments, her chairmanship of the Gosport Primary Care Group and her clinical assistant role on the wards at Gosport War Memorial Hospital.

I did not want to add to her burden of work by insisting that every contact with the patient to be recorded.

It was my impression until this time, that when a significant change had occurred in the patient's treatment or management, Dr BARTON made a record, as she did on the 18/11/1999 in the notes. I was also aware that Dr BARTON was assiduous in attending to the patients at the request of the nursing staff. This was told to me by various members of the nursing staff, although I cannot remember any particular conversation.

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Therefore while her note keeping may have been poor, I felt that the patients were being appropriately medically managed by Dr BARTON. Also the nursing staff were always well informed as to changes in patients' condition and as to how Dr BARTON had managed these.

With the benefit of hindsight I should have spoken to Dr BARTON about her lack of entries in the medical records. I was undoubtedly influenced by the fact that she was under pressure and she was a very experienced GP and highly regarded by the nursing staff who raised no complaints with me about Dr BARTON.

I have been asked whether I would expect an entry from Dr BART
when Diamorphine is prescribed and administered. I can confir
be made when prescribing controlled drugs.

I would add that at this time in 1999, I was working b
responsibility for an acute 19 bed ward at the Queen Ale
shared with Dr TANDY who worked on a part time basis.
there twice a week and would also visit the ward on an a
comprised of a House Officer (a newly qualified doctor) a
Senior/Specialist Registrar with another team.

I also had responsibility for the 24 beds on Dryad Ward at the Gosport War Memorial Hospital where I conducted a weekly ward round. In addition I had responsibility for seeing patients in Dolphin Day Hospital, at Gosport War Memorial Hospital, every Tuesday morning.

I also conducted an outpatient clinic on alternate Tuesday afternoons at the Gosport War Memorial Hospital.

Dr LORD and I also had responsibility for undertaking ward referrals at Haslar Hospital. These referrals were invariably undertaken in the evenings and when Dr LORD was away I would spend up to three evenings a week up to 9 pm (2100) or 10 pm (2200) at Haslar Hospital.

Therefore while her note keeping may have been poor, I felt that the patients were being appropriately medically managed by Dr BARTON. Also the nursing staff were always well informed as to changes in patients' condition and as to how Dr BARTON had managed these.

With the benefit of hindsight I should have spoken to Dr BARTON about her lack of entries in the medical records. I was undoubtedly influenced by the fact that she was under pressure and she was a very experienced GP and highly regarded by the nursing staff who raised no complaints with me about Dr BARTON.

I have been asked whether I would expect an entry from Dr BARTON in the medical records when Diamorphine is prescribed and administered. I can confirm that an entry should always be made when prescribing controlled drugs.

I would add that at this time in 1999, I was working between 12-14 hours a day. I had responsibility for an acute 19 bed ward at the Queen Alexandra Hospital (QAH), which was shared with Dr TANDY who worked on a part time basis. I conducted full formal ward rounds there twice a week and would also visit the ward on an almost daily basis. My team at QAH comprised of a House Officer (a newly qualified doctor) and a Senior House Officer. I shared a Senior/Specialist Registrar with another team.

I also had responsibility for the 24 beds on Dryad Ward at the Gosport War Memorial Hospital where I conducted a weekly ward round. In addition I had responsibility for seeing patients in Dolphin Day Hospital, at Gosport War Memorial Hospital, every Tuesday morning.

I also conducted an outpatient clinic on alternate Tuesday afternoons at the Gosport War Memorial Hospital.

Dr LORD and I also had responsibility for undertaking ward referrals at Haslar Hospital. These referrals were invariably undertaken in the evenings and when Dr LORD was away I would spend up to three evenings a week up to 9 pm (2100) or 10 pm (2200) at Haslar Hospital.

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I was appointed as Medical Director of Portsmouth HealthCare Trust (the organisational predecessor of East Hampshire Primary Care Trust) in 1998, when I took up my Consultant appointment in Portsmouth. Portsmouth HealthCare Trust ran all the community hospitals in the district - Gosport War Memorial Hospital, St Christopher's Hospital in Fareham, Havant War Memorial Hospital , Emsworth Cottage Hospital and Pertersfield Hospital , as well as all the elderly medicine wards at Queen Alexandra Hospital and St Mary's Hospital. Portsmouth HealthCare Trust also managed all the mental health services in the district, all community paediatrics and all community and health visiting services in the district.

Although nominally my time was split 50/50 between clinical and managerial duties, the reality was that the Medical Director's role involved a huge range of responsibilities which took up far more than the nominally allotted time.

In these circumstances I relied heavily on experienced colleagues, such as Dr BARTON.

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Signed: R. Ian Reid
2004(1)

Signature Witnessed by: E. Greenall

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Form MG11(T)

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

Statement of: RAVINDRANE, ARUMUGAM

Age if under 18: O.21 (if over 18 insert 'over 18') Occupation: CONSULTANT

This statement (consisting of 6 page(s) each signed by me) is true to the best of my knowledge and belief and I make it knowing that, if it is tendered in evidence, I shall be liable to prosecution if I have wilfully stated anything which I know to be false or do not believe to be true.

Signed: A Ravindrane Date: 15/06/2005

I am employed by East Hants Primary Care Trust as a Consultant Physician in Elderly Medicine and have been so employed since 2nd January 2001 (02/01/2001). Prior to this I was a Specialist Registrar working in a number of different hospitals but mainly Queen Alexander Hospital, Portsmouth and Southampton General Hospital. I had been a Registrar from December 1997 until I became a Consultant.

As a Registrar I had qualified as MBBS, a Bachelor in Medicine and Bachelor in Surgery, MD a Doctrat in Medicine and MRCP (UK), a member of The Royal College of Physicians (UK). I qualified and did my training in India and came to Britain in 1989 when I continued my training in the UK.

To become a Consultant I trained as a Specialist Registrar from December 1997 to December 2000. I was accredited as a Specialist in General and Geriatric Medicine. I was accredited by the Specialist Training Authority, which is part of the Joint Committee for Higher Medical Training.

In 1999 my duties would have included working as a Registrar for Dr LOGAN in elderly medicine in QA Hospital. At that time out patient clinics were held at St Mary's Hospital . Dr LOGAN was the Consultant and was my Clinical Supervisor. I was also being trained by Dr REID a Consultant in Elderly Medicine. As such I would attend a Consultant ward round at Dryad Ward on Tuesday afternoon. On occasions when the Consultant i.e. Dr REID was unavailable I would conduct the ward round on his behalf.

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The ward round consisted of meeting of the medical team on the ward at about 2 p.m. (1400). Present would be the Consultant in Charge of the ward, myself as a Trainee Registrar, Dr BARTON , the Ward Sister, Sister HAMBLIN . All the case notes would be on a trolley, which would get wheeled around to every patient. Every patient would be visited and spoken to. The ward doctor would highlight the medical problems of the patient to the Consultant, and would detail what action had been taken to treat the problem. The Nursing Sister would inform the Consultant about the nursing problems i.e. whether the patient was eating, drinking properly, if the patient was suffering pain etc. The Consultant would review the observations charts, prescription charts, medical notes and anything else he deemed relevant. The Consultant would also examine the patient again if necessary and would advise on the future management of the patient, i.e. the patient's future care and treatment and other examinations and investigations. A note would be written in the patient's medical notes, and relevant information would be recorded. The note would normally be dictated by the Consultant to a junior member of staff who would record it.

It would be normal for a ward round to take 3 hours on average.

I have been asked to detail my involvement in the care and treatment of Sheila GREGORY . I have no personal recollection of Mrs GREGORY but from referral to her medical notes BJC/21 I can state:-

On 6th September 1999 I conducted a ward round on Dryad Ward at Gosport War Memorial Hospital. I assume that I was standing in for Dr REID as in the medical note I have made no mention to the fact that it was Dr REIDS ward round. If it had of been Dr REIDS ward round I would have headed the entry W.R Dr REID or an abbreviation RIR. I have recorded on the notes.

6/9/99 - noticed to have left sided facial droop
- now better
- ° visual disturbance

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- ° facial weakness
- no warm weakness
- planter ↓↓

(AF) Small pressure sore
was in retention

Pain and tenderness Rt snuff box

- Aspirin for AF
- x-ray Rt hand
- mobilise
- awaiting MRSA

I have then signed the entry.

It would have been pointed out to me by a member of nursing/medical staff that Mrs GREGORY had had a droop to the left side of her face i.e. weakness of the facial muscles on the left hand side. This droop was now better with no (°)visual disturbance i.e. I would have questioned the patient and ascertained that she did not have a problem with her eye sight i.e. double or blurred vision or even loss of vision. There was no (°) facial weakness or arm weakness on examination. The examination would have tested the muscles in the patient's arm and face. I would have then tested Mrs GREGORYS reflexes and have noted the most important one i.e. Planter, this is a reflex in the sole of the feet. The test revealed that Mrs GREGORY 's planter reflex was normal this is indicted on the notes by the two downward arrows.

The two arrows indicate both sides.

In essence it was reported to me that Mrs GREGORY had had a facial droop that was now better. The test I conducted and examinations made were to assess whether Mrs GREGORY had suffered a stroke. From my entry in the medical notes I can only assume that at that point of time did not have any evidence of having a stroke. It is possible that Mrs GREGORY had

RESTRICTED

had a mini stroke and had recovered.

(AF) - Atrial Fibrillation, this means that her heart rhythm was irregularly irregular i.e. chacotic pattern to the heart rhythm.

Mrs GREGORY had a small pressure sore, although I am unable to state where it was and what grade it was. Pressure sores are graded as to their depth and size.

Was in retention relates to the fact that I would have been informed that Mrs GREGORY was in urine retention, indicating that Mrs GREGORY had been unable to pass urine. There are numerous medical reasons for this. I have noted to as it could have been a problem later on and for it to be monitored. Mrs GREGORY had pain and tenderness in the area referred to as her right snuff box. This area is at the bottom of her thumb at the start of her wrist and she would have complained of the pain and I would have found the tenderness on examination.

My management plan for Mrs GREGORY was:-

To prescribe aspirin (as on the prescription sheet page 165) for her atrial fibrillation. This was to thin Mrs GREGORYS blood to prevent strokes.

To ex-ray Mrs GREGORYS right hand to look for fractures for the further investigation of the pain in her wrist.

To mobilise Mrs GREGORY, Mrs GREGROY had suffered a broken hip, mobilisation would develop Mrs GREGORY muscle strength and independence.

At that time I was still awaiting the results of the MRSA screening, this is a routine screening procedure.

Atrial fibrillation can be a risk factor for strokes.

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At this time I cannot say who was present on the ward round with me on that day.

[redacted]

[redacted]

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Form MG11(T)

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

Statement of: Code A

Age if under 18: OVER 18 (if over 18 insert 'over 18') Occupation: DOCTOR

This statement (consisting of 7 page(s) each signed by me) is true to the best of my knowledge and belief and I make it knowing that, if it is tendered in evidence, I shall be liable to prosecution if I have wilfully stated anything which I know to be false or do not believe to be true.

Signed: Dr. P.A.L Gordon Date: 13/10/2005

I am Code A my married name is Code A and am employed as a Consultant Radiologist and am an Associate Director in Medical Education and Director of Breast Screening with Portsmouth Hospitals NHS Trust, Hampshire. I have been Consultant Radiologist since 1988 and held my other two posts since April 2004. I am based at the Queen Alexandra Hospital , Portsmouth, Hampshire.

I obtained a degree as Bachelor of Medicine at the University of Southampton in 1977 and went on to gain a Diploma of Medical Radiodiagnosis in 1982 and became a Fellow of the Royal College of Radiologists in 1985. I was awarded a Master of Arts Degree (MA Ed.) with distinction in 2003 from King Alfred's College, Winchester, (Affiliated to the University of Southampton) and have an accreditation with the Royal College of Radiologists, gained in 1985. I am on the Specialist Register and my GMC number is Code A

My curriculum vitae, prior to my present posts is as follows :

Code A

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Code A

RESTRICTED

Code A

RESTRICTED

Code A

On 7th October 2005 (07/10/2005) I was referred to the medical notes of a Sheila GREGORY , police exhibit reference BJC/21 , and specifically to page 127 of 346 of those notes, this being a diagnostic imaging report by me, the examination date being 07/09/1999 and date of dictation 09/09/1999.

Firstly, I can say that GREGORY went to the X ray Dept. at the Gosport War Memorial Hospital with a wrist problem. Patients are examined by Radiographers and X rayed. Various Consultants, of whom I was one at the time, would attend from their hospitals three times a week and examine the X rays. The Consultant would then write a report, which would be filed with the patients' records. In this case at the time of the wrist X ray, within the packet of films

Signed: Code A

Signature Witnessed by: Code A

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were photographs of hip and chest X rays, taken at Haslar Hospital. These images were taken on 15/08/1999. I believe that it is likely that I was asked by medical staff at GWMH for a formal report on the images taken. Referring to page 11 of the notes, it looks as though GREGORY went to Haslar where she was diagnosed with a fractured femur. She was transferred to GWMH for continuing care. A doctor at GWMH would have viewed the radiographs. My expertise is in the interpretation of X rays and I would later examine the images in order to give a definitive report on the patients' injuries. Referring to page 67 of the notes, written by a junior doctor at GWMH, I note it is written that there was pain and tenderness in the 'snuff box', ie: the skin on the upper surface of the hand at the base of the thumb and index finger. This was on the right hand of the patient. It was as a result of this that I wrote the report alluded to. I wrote of an intertrochanteric fracture of the right hip. Intertrochanteric means between the trochanters. These are part of the femur. I also wrote that I had viewed the X rays taken at Haslar. I noted that the bones were generally osteoporotic. This means that the bones were thin and brittle, not uncommon in elderly women. Further, I noted that there was a degenerative change in the first carpometacarpal joint. To explain, the wrist is made up of bones named the carpal bones. The metacarpal bones are those in the hand, which lead from the wrist to the fingers. This is a common site for degenerative joint changes. In view of the information I had at the time, I made the specific point that the patient had no bones broken other than the femur.

I do not recall this patient, however I see a great many as patients are referred to me from doctors for the specific purpose of interpretation of X ray images.

Code A

[redacted]

[redacted]

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Form MG11(T)

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

Statement of: FLORIO, JEANETTE

Age if under 18: (if over 18 insert 'over 18') Occupation: REGISTERED GENERAL NURSE

This statement (consisting of page(s) each signed by me) is true to the best of my knowledge and belief and I make it knowing that, if it is tendered in evidence, I shall be liable to prosecution if I have wilfully stated anything which I know to be false or do not believe to be true.

Signed: Jeanette Florio Date: 16/08/2005

I am a Registered General Nurse. I am currently a D Grade Staff Nurse.

My Nursing Midwifery Identification Number is **Code A**

I am currently employed by the Portsmouth Hospitals NHS Trust. I am working at St Mary's Hospital, Portsmouth on the gynaecology unit as a Staff Nurse.

I qualified as a Registered General Nurse in August 1992. I trained at the School of Nursing Queen Alexandra Hospital, Portsmouth.

From 1992 until November 1996 I worked on the new born unit at St Mary's Hospital, Portsmouth as a D Grade Staff Nurse.

From November 1996 until December 1998 I was employed as a D Grade Staff Nurse working night shift on Daedalus Ward at the Gosport War Memorial Hospital. On occasions I was required to work on other wards including Dryad.

My responsibilities as a D Grade Staff Nurse included overall charge of the ward, which consisted of 24 beds. The ward was a mixture of continuing care for elderly patients and slow stream stroke rehabilitation for elderly patients.

I supervised two health care support workers. My responsibilities included administering drugs prescribed to patients.

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I also looked after the patients' general well being during my shift.

It was part of my duties to document the care given to each patient.

Night shift commenced at 2015 and finished at approximately 0745.

During the night I was occasionally asked to check the administration of a controlled drug on another ward. This is a standard requirement as laid down by the Nursing Midwifery Council and formerly known as the United Kingdom Council (UKCC).

My experience in the use application of Syringe Drivers began whilst working on the newborn unit, neonatal at St Mary's Hospital.

At that stage between 1992 and 1996 I received training from senior colleagues in the use of Syringe Drivers. The Syringe Drivers were used for delivering intravenous drugs to newborn babies.

I received training for competence in the administration of intravenous drugs and additives on the 28/01/1991 (28/01/1993).

When I commenced working at Daedalus ward in November 1996 I was given supervision from senior colleagues in the administration of drugs delivered subcutaneously via a Syringe Driver to patients requiring palliative or terminal care.

I can recollect using Graseby model Syringe Drivers on Daedalus ward and later when I worked on Dryad ward.

From December 1998 until May 2001 I worked as an E Grade Staff Nurse on Dryad ward, which was on day shifts. I can confirm that I was on duty as a D Grade Staff Nurse for night duty on the 16th and 17th October 1998 (16 and 17/10/1998) on Dryad ward.

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I have been asked to detail my involvement with the patient Sheila GREGORY Code A

I do not remember this patient or treatment administered to her.

I have been shown the medical records relating to Sheila GREGORY (exhibit BJC/21.)

I can confirm that on page 235 (exhibit BJC/21) I have completed a number of the entries on the general information sheet in relation to this patient.

This sheet basically records the personal details of the patient and relevant contact telephone numbers of relatives. Under her personal details I have recorded the fact that the patient was allergic to Penicillin and Septrin.

Penicillin is a common antibiotic. I am not sure what Septrin is- I believe I would have checked at the time to find out what this drug was.

Within this information sheet I have not written the address Code A nor have I written "Please do not contact this lady" or the telephone number Code A

I can confirm that I have written on page 236 of the medical records, which is a continuation of the admittance summary, which is as follows;

PMH = Past Medical history.

Hypothyroidism = under active Thyroid Gland.

Hypertension = High Blood Pressure.

Left Ventricular Failure - (This is an incompetent Left heart muscle which is failing).

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Slow AT- Atrial Fibrillation the muscles of the Atrial are not contracting effectively therefore not pumping satisfactorily.

Mitral Regurgitation- The Mitral valves in the heart are not closing properly.

Asthma - This is self explanatory.

Depression-

Confusion- As per my entry written on p237.

Dementia? - This is not a formal diagnosis of dementia.

Recent # R NOF - Recent Broken neck right neck of Femur.

This Past Medical History (PMH) would have been obtained from the medical notes and /or from the discharge letter from Haslar hospital.

At the bottom of page 236 I have not written the following entry; *Lived at Alec Rose House/ Widow has a daughter and a grand daughter.*

I can confirm that on page 237 of the medical notes I have written the following entries in the Summary of Significant Events;

03/9/99 - Admitted to Dryad ward from Haslar hospital, E5. On 15/08/99 Sheila fell and fractured her right neck of femur. She now has a dynamic hip screw. She mobilises with help of one nurse using a Zimmer frame. She has an in dwelling Catheter and can be incontinent of Faeces. Sheila can become very confused at times, and needs orientating to time and place.

To clarify this entry- she has undergone surgery to have the fracture to her hip stabilised with a dynamic hip screw.

"Indwelling" means she had a permanent Urinary catheter to draw urine from the bladder.

PM
Small wound on lower right leg- steri-stripped covered with paranet, gauze, and bandage.

To clarify this entry the small wound was dressed with steri-strips, which held the edges of the wound together, normally used on fragile skin. Paranet is gauze impregnated with soft paraffin, which is similar to Vaseline which prevents adherence to the wound.

Grand daughter doesn't see her mother very much-apparently- This is self explanatory.

I can confirm that I have written the following entries on page 205 of the medical records. However I must point out that although I was the named nurse, I was not actively involved in her day to day care.

Page 205 of the medical records is the care plan for the wound to her lower right leg. Included within the plan is the desired outcome of proposed treatment, which is as follows;

Problem/Need Number

03/9/99 1. Sheila has a wound to the skin on her lower right leg.

01/10/99 2. Wound just below left knee, outer aspect.

Desired Outcome *To heal wound.*
To prevent further breakdown of damaged area.

Evaluation Date or Interval *Daily*

1. *Clean wound with saline(if necessary).*

2. *Dress with paranet and cover with gauze & cling bandage.*

3. *Renew dressing/wound regularly.*

12/9/99 Duoderm applied (This entry written by S/N Barker).

1/10/99 Bioclusive in situ.

2/10/99 Granuflex applied - change 3-5 daily or as needed.

To clarify these entries *"Cling bandage"* this is a light open weave bandage, which was used to secure the dressing.

"Bioclusive insitu" This is a transparent sterile dressing, which was used- This is applied to allow visualisation of the progress of the wound.

I have written the following entry on page 209 of the medical records, which is under the heading Nursing Care Plan.

3/9/99 Sheila may be prone to constipation and can be faecally incontinent.

The rest of this care plan was written by Staff Nurse COLLINS.

On page 215 I have written the following entry;

Sheila has a Urinary catheter - Basically I had written that she had a catheter when she was admitted.

On page 217 of the medical records I have written-

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Sheila needs help with her personal care.

Under the heading Desired Outcome I have written - *To achieve a level of personal hygiene acceptable to Sheila.*

Under the heading Evaluation Date I have written - *Daily*

Under the heading Nursing Action I have written- *Offer daily bath, wash at bedside- assist. Assist with dressing and grooming. Ensure privacy. Keep nails trimmed and clean. Check skin integrity daily & report if necessary. Offer hairdresser (Fridays).*

These entries are self explanatory.

On page 223 of the medical records under the heading Nutritional Assessment Tool I have written Sheila GREGORY's name at the top of the form.

On page 227 of the medical records under the heading Mouth Assessment Tool I have written Sheila's name at the top of the form. This form however was not completed.

On page 231 I have written Sheila GREGORY's personal details. This form is an index of patient's problems. The problems listed are as follows;

1) *Handling profile* - This deals with any difficulties in moving & handling Sheila whilst in bed. Transferring from chair to bed to toilet.

2) *Mouth assessment/ Nutritional assessment* - Sheila GREGORY fell into the category of "High risk of malnutrition". Mouth assessment involved oral examination of teeth and general health of the mouth. Nutritional assessment involves assessing whether the patient had any special dietary needs.

3) *Personal Care*- This involves her personal hygiene and grooming needs.

4) *Elimination- Urinary catheter -Care* - Which means the patient would need specific care re her catheter. Prevention of infection and physical trauma.

5) *Elimination- Bowels-* This covers her faecal incontinence and constipation which includes suggested nursing care i.e. suppositories.

6) *Wound care-* This covers the care that Sheila had on her right leg.

7) *Sleeping* - This covers any problems Sheila had with her sleeping routine.

8) *Nutrition-* This would cover any specific dietary needs Sheila had.

Care Plans are plans of nursing care proposed for the patient whilst on the ward. These can be carried on in the Community on discharge. It also serves as a record of care that has been carried out by all nursing staff involved in the patient's care.

A named nurse is basically a requirement of the Patients' Charter, which states each patient should have a named nurse. This does not mean that all patient care is carried out by that nurse. Ideally the named nurse should assess, plan, implement and evaluate the patient's care.

Practically this would not be possible. Therefore, other nurses may amend care plans as necessary.

The named nurse is someone that the patient and relatives can refer to where necessary. Ideally named nurses would be responsible for referral to other members of the multi disciplinary team e.g. Physiotherapists, Dieticians and Social Services.

In 1999 ward rounds were conducted by in house Dr BARTON, which normally took place in the morning. I cannot remember the time or how often. It would have been around 8am

RESTRICTED

(0800) before she went to morning G.P Surgery. She would be accompanied by the nurse in charge. She may not have seen all patients - usually it was those that had been brought to her attention with a particular problem by nursing staff.

The consultant's ward rounds were once a week normally accompanied by Gill HAMBLIN the ward manager. The ward round would last most of the afternoon. Each patient would be seen. It also gave relatives opportunities to make appointments to discuss any concerns they may have.

TLC - This means quite poorly- Keep comfortable.

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Form MG11(T)

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

Statement of: HAMBLIN, GILLIAN ELIZABETH

Age if under 18: (if over 18 insert 'over 18') Occupation: NURSING HOME NIGHT SISTER

This statement (consisting of page(s) each signed by me) is true to the best of my knowledge and belief and I make it knowing that, if it is tendered in evidence, I shall be liable to prosecution if I have wilfully stated anything which I know to be false or do not believe to be true.

Signed: G HAMBLIN Date: 15/09/2005

I am Gillian Elizabeth HAMBLIN and I live at an address known to Hampshire Police. I am currently employed as a Night sister in a local Nursing Home. Up until February 2004 when I retired from the GWMH I was a Clinical Manager (Senior Sister) at Dryad Ward, my Nursing and Midwifery Number is Code A I did not work at that hospital however since May 2003 though Code A

In 1963 I became a Cadet Nurse and commenced a 3 year qualification course in 1965 at Hackney Hospital, East London. I worked on all wards until my qualification as a Registered Staff Nurse to the surgical ward.

I commenced employment at Gosport War Memorial Hospital in 1988 in the capacity of Staff Nurse

I was responsible for 24 hr care of the patients on Dryad Ward. I was also on a rota list for the management Redclyffe Annexe which was 23 bed unit caring for long stay palliative and terminally ill patients. We also shared care patients which gave relatives a break from caring and gave them a period of respite.

Redclyffe Annexe was situated a short distance from the hospital and moved to Gosport War Memorial in 1995 and thus became Dryad ward comprising of 20 beds.
Redclyffe then became a 15 bed unit which was taken over by the Mental Health department. When on duty at evenings and weekends we had managerial/ Clinical responsibility when required.

In January 1996 I was working as a Clinical Manager at the GWMH. I worked 37½ hours a week on a shift rota, earlies being 0730 to 1615 and lates 12 midday to 2030.

I was responsible for 24 hr care of the patients on Dryad Ward. I was also on a rota list for the management of the Hospital and would take on management roles when there were no managers at the hospital, i.e. at weekends and evenings. I was responsible for all of the staff on the ward re the training, hiring discipline, staff rotas and leave issues.

My line manager at that time was Barbara ROBINSON .

In 1999, Diamorphine Syringe drivers were introduced to those of us working on Redclyffe Annexe and in 1998 Dr Jane BARTON became the Doctor responsible for the patients, prior to this, each patients GP was responsible for their individual patients on the ward.

Responsibility for medical care was "Elderly Medicine" based at the Queen Alexandra Hospital Cosham.

Dr BARTON would visit at 0730 each morning Monday to Friday and see every patient, before returning to her own practice.

She would return to the GWMH to check in and arrange to see relatives either that day or later.

On her visits Dr BARTON would prescribe the drugs that were required by each patient. This was a new concept to staff at this time. Sister GREEN who was in charge at this time bought syringe drivers to the annexe and explained the system to the nurses and they would have learnt their use from her.

At this time there were no courses in the use of syringe drivers, but these have since been started. I am aware that there have been some concerns in relation to the syringe drivers and diamorphine , but I have not had any doubts myself. The main reason for the use of a syringe

driver is to administer drugs to a patient once oral medication has ceased, generally due to the patient's inability to swallow.

Drugs that I am aware of that have been administered in this way as well as Diamorphine, are Midazolam , a sedative, Hyoscine , to stop secretions and Cyclizine to stop vomiting.

I have been asked about the "Wessex Protocols". I am unfamiliar with this name but am aware of certain protocols I relation to the setting up and use of syringe drivers and am unsure if they are one and the same.

The Named Nurse is the person with the responsibility for the nursing care of the patient. The named nurse would also be the person to whom the family would speak to, in order to keep them up to date on the patient's condition.

The time and date of all entries in the nursing notes would either be completed at the time if the patient was seriously ill, but in other cases they would be completed when there was time but in any case at the end of the tour of duty.

I have been asked to detail my involvement in the care and treatment of Sheila GREGORY b. Code A I cannot recollect this patient or the subsequent treatment that she received.

From referring to her medical records (exhibit ref BJC/21) page 7. I can confirm that I have written entries on the Spell summary.

The spell summary is the discharge summary, primarily for the benefit for the patient's own Doctor to inform them of the treatment the patient has received whilst in hospital.

A copy is also forwarded to Clinical coding at Portsmouth.

I can confirm that on the 22/11/99 I have written the following

RESTRICTED

Diagnosis

 # NOF this is a Fracture to the neck of Femur. (That is the patient had broken the top half of the thigh)

Recorded on the spell summary are the patient's personal details and contact numbers.

Under the heading "Date of Discharge" I have written the date of death as *22/11/99* and signed the entry.

The patient Sheila GREGORY was diagnosed "broken neck of Femur" this procedure may well have contributed to her death. However from referring to the Clinical notes I note that Doctor BARTON has written down under her Past medical History (PMH) on page 66 of the records as having suffered from;

Cardiac Failure = (Heart Failure)

Hypothyroidism = (Under Functioning thyroid)

I note that on page 70 of the medical records that Dr BARTON has written "*Further CVA?*" CVA = (Cardiovascular Accident/Stroke). I cannot find any reference to a previous CVA.

However cause of death in my opinion is most likely to be a CVA.

I can confirm that I have countersigned the entry written by Staff Nurse Freda SHAW which is recorded on page 70 of the medical records (BJC/21). This entry confirms that the correct procedure for verifying death has been complied with. Two trained members of nursing staff need to be present.

Checks to the patient's vital signs were conducted which show that there was no Carotid artery pulse.

There was no Radial pulse. There was no heart beat when listening through a stethoscope.

There was no pupil reaction to light. No visible respiration was observed. There were no inspiratory sounds of breathing when using a stethoscope.

Relatives would be informed at the earliest opportunity.

I was not involved in the admission of this patient on the 3/9/99.

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Ward rounds were conducted on Dryad ward by Dr BARTON at 0730 Monday to Friday. She was accompanied by the senior trained nurse in charge of the ward which was normally myself. The ward round would have to be finished by 0810 as Dr BARTON would then have to conduct a ward round on Daedalus ward.

Consultant ward rounds were conducted once a fortnight on a Monday afternoon normally accompanied by Dr BARTON and the senior trained nurse on duty.
The treatment of each patient was based on the observations of all the nursing staff. These observations would then be passed onto the Consultant.

I can confirm that on page 136 of the medical records I have recorded that I have given Sheila GREGORY a dose of Oramorph, the entry reads as follows;

17/11/99 2020 5mgs/2-5mls This was given orally to the patient.

Again on page 136 of the records I have recorded that I have given Metoclopramide to the patient the entry reads as follows;
11/11/99 1615 10mgs. This is not a controlled drug and would have been given for either nausea or vomiting. This was prescribed over the phone as a result of me ringing Dr BARTON and asking for something to stop the patient's vomiting or nausea.
There is no record within the nursing notes recording the fact that the patient was suffering from vomiting or nausea for this date. This drug was only administered on one occasion.

I can confirm that on page 151 of the medical notes I have written the following;

Magnesium Hydroxide 20mls BD =(Twice Daily) This was a verbal order taken on the phone from Dr BARTON which has subsequently been signed by Dr BEASLEY from the same practice who actually attended and authorised the prescription of Magnesium Hydroxide. This entry written by me was subsequently crossed out by Dr BARTON.
On page 151 of the medical records there is an entry for Magnesium Hydroxide with a reduced dose of *10 mls BD.* This entry has been signed by Dr BARTON.

RESTRICTED

Magnesium Hydroxide is a bowel preparation which is quite gentle on the bowels and not as strong as other preparations.

I can confirm that I have written the following entries in the medical notes of Sheila GREGORY commencing on page 238 which are as follows;

4/10/99 Seen by Dr REID continue to encourage food and fluids. Physio to commence this week.

This entry is self explanatory.

7/10/99 Generally unwell. C/o = (Complains of) *acute pain on top of head and side of face. Feeling nauseated. Rested on bed feeling better.*

This entry is again self explanatory.

15/11/99 Seen by Dr REID - Thyroidizine discontinue.

I note from the medical records that Thyroidizine was last given on the 7/10/99 at 0200. From memory Thyroidizine was no longer being used in Elderly care as it was being withdrawn.

I can confirm that I have written the entry on page 238 which is as follows;

19/11/99 - Poorly but stable morning -c/o shortness of breath this afternoon.

Frusemide 40mg given start at 1530. No residual urine. Drained 200mls in the first ½ hour following Catheterisation. Continue Oramorph.

To clarify this entry - Although Sheila GREGORY was unwell she was stable. She had complained of shortness of breath. Fruesmide which is a Diuretic was prescribed by Dr BARTON on the 19/11/99 at 1530hrs.

This is recorded on page 184 as a verbal message taken by me and countersigned by Staff Nurse Freda SHAW.

If a verbal order is given over the phone then where possible a second trained nurse was required to countersign any entry for the prescription of drugs.

As shown in this case Fruesmide was prescribed because it will relieve the fluid in her kidneys

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and around her lungs which in turn will hopefully improve her breathing.

I have written the following entry on page 239 of the medical records

20/11/99 (I believe this entry was written in the morning) *Some deterioration during the morning Grand daughter advised to visit AM Vomited also- Cyclizine 50mgs IM* = (Intramuscularly) *1315 I/C* = (with) *good effect* (This was a one off dose that was given)

PM Good relief from Cyclizine IM Syringe driver commenced at 1700 with Diamorphine 20mgs and Cyclizine 50mgs. Please contact Pauline GREGORY during the night if sudden deterioration.

To clarify this entry - The patient was obviously getting worse. I would have rung her grand daughter and advised her to visit Sheila GREGORY.

She was prescribed Cyclizine as she had previously been vomiting.

Diamorphine was prescribed and given at this time to relieve her distress and discomfort.

At this stage Sheila GREGORY was dying.

I can confirm that I have signed the following entries within the Dryad ward Drugs register exhibit JP/CDRB/48 commencing on page 4 as follows relating to the administration of Diamorphine.

20/11/99 1700 Sheila GREGORY 20mg G.HAMBLIN witnessed by L.BARRETT

I can confirm that I have written the following entries in the Drugs register for Dryad ward for the administration of Oramorph which are as follows;

18/11/99 1030 Sheila GREGORY 5mgs/2.5mls G.HAMBLIN witnessed by F.SHAW
18/11/99 1430 Sheila GREGORY 5mgs/2.5mls G.HAMBLIN witnessed by L.BARRETT
19/11/99 1020 Sheila GREGORY 5mgs/2.5mls G.HAMBLIN witnessed by L.BARRETT

I would not necessarily check the nursing notes or clinical notes of the patients on the ward

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when I came on duty. However there was always a handover from nursing staff from the previous shift who would report on all patients. All changes would be reported to the incoming staff.

At a later stage normally when I was writing my notes in the patient's medical records I would check the previous entries of the nurses and Doctors if they were legible.

I had no further dealings with Sheila GREGORY.

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Form MG11(T)

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

Statement of: BARRETT, LYNNE

Age if under 18: (if over 18 insert 'over 18') Occupation:

This statement (consisting of page(s) each signed by me) is true to the best of my knowledge and belief and I make it knowing that, if it is tendered in evidence, I shall be liable to prosecution if I have wilfully stated anything which I know to be false or do not believe to be true.

Signed: L BARRETT Date: 22/07/2005

I am the above named person. I reside at an address known to the Hampshire Police.

I qualified as a SRN in 1972 at the Hull Royal Infirmary.

I have 32 years experience as a Registered General Nurse (RGN).

In 1987 I was working at the Redcliffe Annexe as an RGN.

I believe it was in 1994 that the Annexe was closed and the patients and staff were transferred to the Dryad Ward at the Gosport War Memorial Hospital (GWMH). At this time I was an E Grade RGN.

I am currently an E Grade staff nurse on the Sultan Ward at the GWMH.

My nursing Midwifery Council Pin No is **Code A**

My responsibilities on the Sultan Ward were tending to the day to day running of the ward. This includes supervision of junior staff, caring for the patients, administration of prescribed medicines.

I have been using syringe drivers since 1987 or 1988. I was given on the job training by the Clinical Manager on the ward at the Redcliffe Annex by Sister Gill HAMBLIN . I was shown

how the syringe driver worked, how to book the prescribed drugs out from the drugs register which were to be used in the syringe driver. I can recollect that we were also informed which prescribed drugs could be mixed in the syringe driver and which drugs were not suitable for mixing.

The only prescribed drugs that I would not mix together in a syringe driver are Haloperidol and Cyclazine. This is because when these two drugs are mixed the solution turns a milky colour. Nursing staff also received tutorials from pharmacists who came on to the ward.

We were advised which drugs were not to be mixed, especially when administering large doses. For example Hyoscine was pointed out as being toxic and had to be diluted more thoroughly. It would be administered in another syringe driver.

I worked a 37½ week on the ward. The shift pattern consists of early which either starts 0730 to 1530 or 0730 to 1300. Lates are 1215 to 2030. Nights commence 2015 to 0745.

Dryad Ward consisted of 20 beds. The majority of the patients are aged over 75. Currently the Dryad Ward is closed as a continuing care assessment ward.

I should mention that with regards to syringe drivers it is policy that two trained nurses are present when the driver is set up with the required prescribed drugs.

I am aware of the Analgesic ladder, i.e., the pain ladder. Basically this refers to the strength and type of drug given to a patient. This starts from the simple paracetamol through to drugs containing codeine, then onto weak opiods then onto the opiates, i.e. Oromorph and Diamorphine.

Drugs and dosages given to patients are sometimes based on the 24 hour observations of nursing staff. These observations are passed onto the doctor when he or she is conducting their ward round. Or if necessary if in more urgent cases the Doctor may well be phoned.

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From 5pm (1700) to 7am (0700) the hospital is covered by Primecare deputising Doctors Service.

Syringe drivers are used when patients cannot swallow oral medication. The driver is an effective way of delivering pain and or sedation relief over a 24 hour period without the peaks or troughs.

The guide lines for obtaining prescribed drugs to be administered to patients whilst on Dryad Ward is rigidly controlled.

Drugs can only be prescribed by a doctor, a record of drugs is written into the patients prescription chart.

Controlled drugs are stored in a locked cupboard within a locked cupboard. The keys to these cupboards are only held by trained nursing staff.

It requires two trained staff firstly to check the prescription chart relating to the patient to ascertain that the controlled drug is still required and that it has been authorised by a doctor.

The next step was to check the time of the previous administration of the drug(s) given to the patient. Then both of the trained nurses would take the drug chart to the drugs cupboard where the drugs are stored. A check would be made to ensure that the correct drug is withdrawn and verify the dosage required.

Once both members of staff were satisfied that the drug and dosage was correct then the drug register was completed but not signed at this stage.

In the case of controlled drugs to be administered through a syringe driver the drug(s) have to be mixed with a measured amount of sterile water. In 1996 the standard amount of sterile water mixed with the drug was 10mls.

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The quantity of solution containing the drugs has to be sufficient to last over the 24 hours that the syringe driver is delivering the required hourly dose.

When the syringe driver was initially set up the connecting line from the syringe driver to the patient had to be charged, i.e., filled with the solution from the driver. This usually takes about ½ ml of the solution.

It therefore follows that the initial dosage takes less than 24 hours to complete. This is because there is a quantity of the solution still left within the plastic line connected to the patient.

Subsequent driver administrations given to the patient will then take the 24 hour period to deliver the required dosage.

At the completion of each syringe driver administration the plastic line will always contain ½ ml of the solution.

The amount of sterile fluid solution mixed in the syringe driver has now been reduced to 8mls which is a set standard.

The subcutaneous needle which is inserted into the patient is usually changed every 72 hours. This is just to make sure that the patient is comfortable with the needle and there is no soreness.

With reference to the mmls (milli mols per hour). The standard delivery rate today is 48mmls which will deliver the dosage through the syringe driver in 24 hours.

In 1996 the normal rate for setting the syringe driver was between 50 and 52 mmls per hour. This was because there was a larger volume of fluid contained within the syringe driver.

Entries written in the nursing notes would normally be completed at the end of a tour of duty, except if it was an important entry when it would be done at the time.

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Since October 2005 I have been employed as a Staff nurse band 5 on Sultan ward Gosport War Memorial hospital.

As far as I can recollect ward rounds in 1999 were conducted once a week. Doctor REID was the Consultant Geriatrician for a period of time. The ward round was conducted with the senior staff nurse on duty.

Doctor BARTON would normally be present for ward rounds conducted by the Consultant in the afternoon, I am not sure whether she was present for ward round in the morning.

It was normal practice for the receiving ward to phone the ward that was transferring the patient to obtain an overview of the new patient. Details such as whether the patient required a special mattress, dietary requirements, the patient's mobility, whether they were suffering from pressure sores.

Details of the patient's drug regime were also obtained from the transferring ward.

I have been asked to detail my involvement in the case of Sheila GREGORY dob Code A

Doctor BARTON would normally assess a patient on admittance to Dryad ward unless she was on holiday.

It was my practice when a patient had been admitted to speak to Dr BARTON to ascertain whether there was anything I need to know about the patient.

I would have checked the notes written by Dr BARTON on page 66 of exhibit BJC/21 relating to Sheila GREGORY's admission. My interpretation of the notes are as follows;

Sheila GREGORY was transferred Dryad ward for continuing care. She had suffered a broken neck of Femur, on right side.

Her past Medical History (PMH) included Hypothyroidism, Cardiac Failure. She was also incontinent.

She required two to transfer. Her Barthel score was recorded as 3-4 which is quite low. This may explain why there is a question mark/ query re Nursing home in the medical notes.

"Plan"- Get to know (Which is what the medical team were going to do, during the time, the patient was on the ward)

"Gentle rehab"- Try and get her on her feet but keep within the patient's limits.

"Please make comfortable"- This is to make sure she has everything that she needs.
Staff will monitor her pain as she has undergone a major operation, especially at the age of 91.

"I am happy for nursing staff to confirm death"- Nursing staff can only verify death not confirm. Basically Dr BARTON was not always on the ward. It enabled staff to administer the appropriate treatment and nursing care to the patient if they had taken a turn for the worse. This prevented the patient having to wait around especially when Dr BARTON was in surgery.

When a patient died, nursing staff were able to verify death, without having to wait for Dr BARTON to attend.

Nursing staff continue to verify death. It is always conducted by two trained 1st level nurses.

I can confirm that I have written the following entry in the medical notes page 237 (exhibit BJC/21)

S/B Dr RAVI C/O *painful ® thumb same to be x-rayed? # Scaphoid NAD* (No abnormality detected)

To clarify this entry on 6/9/99 the patient has been seen by Dr RAVIDRANE.

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Sheila GREGORY has complained of a pain to her right thumb. As a result an X-ray was ordered.

On examination of the X-ray no abnormalities were detected.

I can confirm that I have written the following entry on page 237 of the medical notes.
PM 13/9/99

Sheila's great grandson has informed me that she no longer resides at Alec Rose house.

Please see front sheet for new address.

This document shows the patient's personal details and contact telephone numbers.

I have written the following the following entry on page 239 of the medical records as follows;

17/11/99
Not very well this evening. Becoming quite distressed and breathless at times.
Oramorph 5mg/2.5mls given 2000 to relieve distress. Good effect (i.e. the dose worked effectively)

Although this entry was written by me, I did not administer the Oramorph it was administered by Gill HAMBLIN and witnessed by Irene DORRINGTON at 2020 hrs as recorded in the drugs register page 62 (exhibit JP/CDRB/24)

I can not recollect the reason why I wrote the entry in the nursing notes. It is possible that Gill HAMBLIN may have asked me to write the entry.

The next entry I have written is also on page 239 of the medical records, which is as follows;

RESTRICTED

18/11/99 Still unwell today. Feeling quite anxious after discussion with Dr BARTON it was felt that Oramorph 5mg/2.5mls given on a regular basis 4 hrly (hourly) *would be of benefit.*
Oramorph 5mg/2.5mls given 1030hrs 1435hrs 1830 hrs.

To clarify this entry the patient was still unwell. I have spoken to Dr BARTON discussed options on how to calm Mrs GREGORY's symptoms down.

It is probable that as the previous dose of Oramorph administered to Mrs GREGORY had worked. It was decided to administer the same dosage of Oramorph on a regular basis, rather than a one off dose.

I can confirm that I have written the following entry on page 62 of exhibit JP/CDRB/24 which is the Dryad ward drugs register for Oramorph.

18/11/99 1830 Sheila GREGORY 5mgs/2.5mls L.BARRETT

I have witnessed the entry on page 62 for the same dose of Oramorph dated 18/11/99 at 1430 hrs. This dose was administered by Gill HAMBLIN.

Again I have witnessed the entry on page 63 for the same dose of Oramorph dated 19/11/99 at 1020 hrs which was administered by Gill HAMBLIN.

I had no further dealings with the patient Sheila GREGORY.

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Form MG11(T)

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

Statement of: BELL, ELIZABETH JANE

Age if under 18: OVER 18 (if over 18 insert 'over 18') Occupation: STATE ENROLLED NURSE

This statement (consisting of 7 page(s) each signed by me) is true to the best of my knowledge and belief and I make it knowing that, if it is tendered in evidence, I shall be liable to prosecution if I have wilfully stated anything which I know to be false or do not believe to be true.

Signed: E J BELL Date: 31/10/2005

I am the above named person and reside at an address known to the Hampshire Constabulary.

I am a state enrolled nurse. I qualified as a nurse in September 1980. I received my training which was a 2 year course at the West Cumberland Hospital, situated in Whitehaven, in Cumbria

As soon as I qualified as a state enrolled nurse in 1980 I moved address to London. I then worked at Guy's Hospital in London. Whilst I was working at Guys I covered the night shift at a variety of wards. I also worked at Lewisham Hospital Lewisham, South East London.

At Lewisham Hospital I worked for approximately 3 months predominantly on the children's ward.

I believe it was in May or June of 1981 that my husband and I moved to live in Gosport, Hampshire.

I believe it was at the end of 1981 that I commenced work at the Home of Comfort situated in Southsea, Hampshire. I worked at this home (which cared for elderly people) for approximately 12 months.

Between 1982 and 1987 I was not employed being fully occupied with being a housewife and mother to my children.

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I can remember returning back to work as a SEN at the Crescent Rest Home, The Crescent, Gosport. I only worked part time in the evenings looking after the elderly patients who were resident at the home. My duties involved administering prescribed drugs to the residents at the home, which had been prepared by the staff nurse at the home. I was involved in the general care of the resident giving help where needed. I believe I worked at the Crescent Rest Home between 1986 and 1987.

After my second child was born in 1987 I then worked as a nursing auxiliary obtaining employment through the Crown Nursing Agency, which was based at Lee-on-Solent, Hampshire.

As far as I am able to recollect I worked as an auxiliary nurse for a period of 2 years. I only worked at limited times when my husband was working at home.

I worked part time at the Langdale Nursing Home in The Avenue, Gosport as a carer of elderly residents.

During the period from 1980 up to date I have always maintained my nursing qualifications, which are renewed every 3 years.

In January 1996 I went to work as carer (now called Health Support Worker) at the Dryad Ward, Gosport War Memorial Hospital, Bury Road, Gosport. Initially I worked between 10am (1000) to 2pm (1400). I then increased my hours to 30 hours a week. My duties at this time involved looking after the elderly patients who required continuing care, i.e., general everyday personal care.

I believe it was during May 1998 that I then started working on the Dryad Ward as a State Enrolled Nurse. For the first 3 months I was working alongside my mentor, Staff Nurse Freda SHAW.

During this period of time I undertook refresher training in the use of administering drugs

including controlled drugs, to the patients on Dryad Ward. The drugs were kept in a secure trolley. The controlled drugs were stored within two secure cupboards. I also received refresher training in the use of dressings which are applied to patients.

I was also given training on peg feeds that is where patients who cannot swallow/eat food are given a form of liquid food directly into stomach.

My duties at this time involved looking after approximately 4 carers on the ward ensuring that the patients were properly cared for. I was responsible for the daily routine care which includes administering drugs to the patients, clinical dressings, assisting in the feeding of patients, assisting relatives who visited their relatives in the ward. I also assisted in feeding patients where necessary.

I was responsible for appraising the Staff Nurse with any problems on the ward during my tour of duty.

My duties were between 7.30 (0730) to 1.30pm (1330) and 2.15pm (1415) and 8.30pm (2030).

I am not sure of the date but I believe it was in 1999 myself and other members of staff received training at the QA Hospital relating to the use of syringe drivers . The training covered how to set up a syringe driver.

A syringe driver would be set up by two qualified nurses and this would only be on a doctors instructions.

I have been asked if I recall a patient named Sheila GREGORY . I do not remember this patient at all. I have been shown a set of hospital notes laBELLed BJC/21 . Page 197 of the notes seems to be the start of the Nursing Care Plan, it has the patients name at the top and alongside Named Nurse it has S/N D. BAKER and S/N E. BELL. The Named Nurse is responsible for that particular patient. For example if a patient needed a dressing changed for instance then the named nurse would be asked to do this. We were probably both named nurses for this patient as

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we had both just moved into our roles and were gaining experience.

I have been shown page 208 of the notes and can see that I have written in the following entries:

19-10-99 redressed as per plan
22-10-99 Redressed as per plan.
28-10-99 Redressed with Paranet.
3-11-99 Skin flap to Lt arm healed. Skin flap to Rt hand dressed with Cutinoba foam, please leave 3-5 days.

A skin flap is where the skin comes away from often caused by knocking or that sort of thing. Part of the nursing plan was to promote healing and prevent infection.

On page 210 I have written the following ;
25.9.99 BO Supps given x2 B.W.O.
I have signed the entry.

This means that Sheila GREGORY had constipation, that she was given suppositories and that this caused her bowels to open as desired and in accordance with the nursing plan as written up on the preceding page.

On page 212 I have written the following;
BO Soft Brown formed.
I have signed the entry. The entry shows that her stools were good.

On page 214 I have written the following:
6.11.99 Supps x2 given very small result.
I have signed the entry which is self explanatory.

On page 216 I have written a further entry:
2.11.99 Passed Urine.

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I have signed this entry. The entry relates to page 215 which shows that her catheter was removed on 28/10/99.

Page 217 shows that part of the plan was to achieve a level of personal hygiene for Sheila. Consequently I have an entry on page 218;

16.9.99 Full wash given.

Again I have signed the entry/.

Page 222 shows a similar entry again signed by me;

2.11.99 Full wash given.

These entries are in keeping with the nursing plan.

MG11T

HAMPSHIRE CONSTABULARY

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WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

URN //

Statement of : Betty Packman

Witness Contact Details

Code A

Witness Care

a) **Is the Witness willing and likely to attend court?** ☒ Yes ☐ No

If 'No', include reasons on form MG6. What can be done to ensure attendance?

b) **Does the witness require 'special measures' as a vulnerable or intimidated witness?** ☐ Yes ☒ No

If 'Yes' submit MG2 with file

c) **Does the witness have any specific care needs?** ☐ Yes ☒ No

If 'Yes' what are they? (Healthcare, childcare, transport, disability, language difficulties, visually impaired, restricted mobility or other concerns?)

Witness Consent (for witness completion)

i) **The criminal justice process and Victim Personal Statement scheme (victims only) has been explained to me:** ☐ Yes ☐ No

b) **I have been given the leaflet 'Giving a witness statement to the police – what happens next?'** ☐ Yes ☐ No

c) **I consent to police having access to my medical record(s) in relation to this matter:** ☐ Yes ☐ No ☐ N/A

d) **I consent to my medical record in relation to this matter being disclosed to the defence:** ☐ Yes ☐ No ☐ N/A

e) **I consent to the statement being disclosed for the purposes of civil proceedings e.g. childcare proceedings (if applicable):** ☐ Yes ☐ No ☐ N/A

f) **The information recorded above will be disclosed to the Witness Service so that they can offer help and support, unless you ask them not to. Tick this box to decline their services:** ☐

Signature of Witness:

Statement taken by (print name): **Station:**

Time and place statement taken:

Signed : _____ Signature witnessed by : _____

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Form MG11(T)

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

Statement of: BARKER, DEBRA

Age if under 18: O.18 (if over 18 insert 'over 18') Occupation: STAFF NURSE

This statement (consisting of 12 page(s) each signed by me) is true to the best of my knowledge and belief and I make it knowing that, if it is tendered in evidence, I shall be liable to prosecution if I have wilfully stated anything which I know to be false or do not believe to be true.

Signed: D BARKER Date: 11/07/2005

I am at present employed by Portsmouth Hospital Trust working as a D Grade Staff Nurse in the new out patients department at St Mary's Hospital, Portsmouth and have been so employed since February 2003.

I am a qualified General Nurse and a registered midwife, the midwife qualifications has now lapsed. I qualified as a general nurse in November 1985 and as a midwife in March 1991. I commenced my training in July 1982 at Hull District School of Nursing, I also attended the Hull School of Midwifery from September 1989 to March 1991.

From November 1985 I worked as a staff nurse at the Princes Royal Hospital, Hull and apart from a year off in 1993 to 1994 I have worked as a Staff Nurse, trained in midwifery or been a staff mid wife at various hospitals in Hull and Hampshire.

From September 1998 to January 2003 I was employed by Portsmouth Health Care Trust working as a staff nurse on Dryad Ward at Gosport War Memorial Hospital. Whilst there I originally worked a sixteen hour week, two eight hour shifts that could have been any two days of the week. It was either 7.30 am (0730) to 4.15pm (1615) or 12.15pm (1215) to 8.30pm (2030). In October 1999 I was working only on a Monday and a Friday from 7.45am (0745) to 4.30pm (1630). I had this arrangement due to child care issues.

As a Staff Nurse my main responsibilities were assessing the care, giving the care and evaluating the care of the patients on the ward. The number of staff working on the ward at any one time varied greatly from 4 people in an evening to 7 or 8 in the morning, these figures are

very approximate. I also supervised health care support workers, ie, untrained members of staff, whilst I would assess the care and evaluate the care of the patient the health care support worker would give the care on their own or with assistance depending on their ability and staffing levels.

As a D Grade Staff Nurse I could administer drugs supervised by a senior nurse, Grade E or F or the ward sister, Grade G. There were rare occasions when I was the senior nurse of the ward, this would have been in the evening. Drug administration was witnessed by a trained member of staff.

There were three different teams working on Dryad Ward during 1999 each team usually consisted of an E Grade Staff Nurse, a D Grade Staff Nurse and the health care support workers. It was set up like this so that each team was supposed to be responsible for six to eight patients and there was always supposed to be a member of that team on duty at any time. It worked well in the morning but in the evening because there was so few staff on duty it was not always practical.

The care of the patients was the main priority of the nursing staff and all the patients were treated with dignity and respect at all times.

Syringe drivers were used on the ward at this time, they administer drugs continuously subcutaneously, ie, under the skin. I would have charged and maintain the driver, although I would have always done this in the presence of another trained member of staff.

I received on the ward training for syringe drivers by other trained members of staff. I had not worked with syringe drivers before, although I had worked with other similar pieces of medical equipment. The training I received could best be described as 'on the job' and was sufficient to allow me to do my job properly. I had no concerns over the use or the training with regard to syringe drivers.

I have been asked to detail my care and treatment of Sheila GREGORY who died on Monday

RESTRICTED

22nd November 1999 on Dryad Ward at Gosport War Memorial Hospital. From referral to her medical records (identification reference BJC/21) , I have no personal recollection of this patient although the name does vaguely ring a bell.

I have made an entry (page 197) that is a care plan for nutrition. It is dated the 22.10.99 and has Sheila GREGORY's name at the top of the form, shows the named nurse as myself and S/N E BELL and reads as follows:

Problem/need number

22.10.99 Sheila has a poor appetite, maybe prone to becoming malnourished.

Desired outcome

To aim to ensure an adequate nutritional intake.

Evaluate date or interval daily

Nursing action

1. Encourage a well balance diet and oral fluids
2. Give small regular meals
3. Give supplements if meals not eaten, ensure/build up
4. May require a food/fluid chart
5. Weigh weekly, weight chart
6. Report any significant weight loss/gain.
7. May require dietician referral at a later date

I have then signed the entry.

This is a basic nutritional nursing care plan to ensure that the patient has an adequate nutritional intake, and is in the whole self explanatory.

Page 198 is an evaluation of the nutritional care plan and I have recorded:

26.10.99 eats well if given small meals.
I have then signed this entry. Again this is self explanatory and I that time I was happy that Mrs GREGORY was having an adequate nutritional intake.

Page 205 relates to a nursing care plan dealing with a wound on Mrs GREGORY's lower right leg.

I have recorded.
12.9.99 Duoderm applied.
I have then signed the entry.

Prior to this date the wound was being treated with purant, this is a liquid paraffin impregnated dressing. As the wound appeared to be healing well I change the dressing replacing it with duoderm. This dressing a small dressing and is self adhesive, it can stay on longer and is more practical.

Page 206 is an evaluation sheet for the leg wounds care plan I have recorded the following.

5.9.99 leg wound dressed steristrips removed parnet + gauze applied, secured with 10cm k band.
12.9.99 wound appears to be healing well duoderm applied
8.11.99 - - - -
12.11.99 wound healed, 9x9 dressing secured with k band for protection only. Legs well greased with 50/50 liquid paraffin.

I have signed each of these entries.

On 5.9.99 I have dressed the leg wound as per the care plan, k band is a type of bandage used to hold the dressing in place. Steristrips are small adhesive strips used to hold wound edges together and are used instead of sutures (stitches). At that time the wound was healing as I did not have to replace the steristrips.

The entry on the 12.9.99 I have already explained.

On the 8.11.99 I have drawn a line across the page, which probably means that I didn't do anything to the dressing, indicating that there was no change with regard to the wound from the previous entry. Drawing a line like that was a common practice in 1999.

Page 207 is a nursing care plan for Mrs GREGORY written by me on 16.10.99 relating to a skin flap on her forearm and I have recorded the following:

Problem/need number
16.10.99 Sheila has a skin flap on her forearm (prior to forearm is an (L) that has been overwritten with an (R). I am unable to say whether it is an (L) or a (R).

Desired outcome
To promote healing and aim to prevent infection.

Evaluation date or interval daily.

Nursing action.
1. Clean with normal saline if necessary
2. Apply paranet and gauze dressings
3. Cover and secure with a k band

I have then signed this entry.

Mrs GREGORY had obtained a skin flap on her forearm during her stay at the hospital. Elderly patients have sometimes very thin skin that can be easily damaged. This injury could have been caused in all manner of ways, basically by Mrs GREGORY's forearm coming into contact with something hard.

The care plan was put in place to promote healing and prevent infection and to achieve this the

nursing action was to clean with saline, a salt solution, apply paranet as previously explained and cover and secure the dressing with a k band (bandage).

On page 208 - an evaluation sheet for the skin flap care plan I have recorded the following:

16.10.99 wound edges realigned dressed with paranet
25.10.99 wound appears to be healing well duoderm applied
29.10.99 wound redressed as per plan
31.10.99 - - -
12.11.99 wound now healed

I have signed all of these entries, they are self explanatory and have been previously been explained when dealing with the leg wound.

It should be noted however that Mrs GREGORY sustained another wound on or about 27.10.99 on her right arm and my entries on 29.10.99, 31.10.99 and 12.11.99 refer to the second wound.

It is clear from the evaluation sheet that both wounds healed satisfactory.

Page 230 is a handling profile relating to moving the patient and her mobility. It list a number of movements, ie, turning/rolling, up/down bed and the require assistance the patient needed from the nursing staff to achieve the movement.

I have signed and dated the form 22/10/99 and it shows at the time Mrs GREGORY was unable do any of the specified movements at best with the assistance of two nurses and at worst, with the assistance of two nurses, or a hoist or she was completely unable. The form is self explanatory.

Page 238 is the summary of significant events relating to Mrs GREGORY and is completed by the nursing staff on it I have recorded:

RESTRICTED

11.10.99 S/B Dr REID ? for H/NH placement, to see grandaughter
I have then signed this entry.

This entry relates to a ward round by Dr REID on 11.10.99 and corresponds with his entry on page 69.

Dr REID had obviously brought up the question of a rest home or nursing home placement and someone was to see Mrs GREGORY's granddaughter regarding this. At this time it appears that Dr REID is planning for Mrs GREGORY's discharge.

25.10.99 social work referral completed to be faxed tomorrow
S/B Dr REID no change
I have then signed this entry.

This relates to another ward round by Dr REID that corresponds to his entry on page 69 on 25.10.99.

A social work referral form is a form that would be completed when plans were being made to discharge a patient to a nursing home or a rest home. They could be for the social services to arrange the rest home, or to fund or part fund the rest/nursing home with the relatives.

1.11.99 S/B Dr REID to continue

I have then signed this entry, and again it corresponds to a ward round and note by Dr REID on page 69.

The nursing care was to continue as before as there was no change in the patient.

On page 240 of the summary of significant events I have recorded:

21.11.99 condition remains poorly, all cares continued

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PM syringe driver recharged at 1705 hrs with Diamorphine 20mgs and Cyclizine 50mgs
I have then signed this entry.

It is obvious that Mrs GREGORY's condition had deteriorated since my last entry and had been poorly/not very well since the 17.11.99 (page 239).

Condition remains poorly, all cares continued. Mrs GREGORY was at this time in bed and was unable to carry out the activities of daily living, all cares continued indicates that every thing was being done for her, ie, turning, washing, feeding if appropriate, it is probable at that time that Mrs GREGORY was unable to move herself and may or may not be responsive, or may or may not be conscious.

At that time Mrs GREGORY was being administered diamorphine 20mgs via a syringe driver. At 1705 hrs I recharged the driver with 20mgs of diamorphine and 50mgs cyclizine. These drugs would have been administered over a twenty four hour period.

Diamorphine is for pain relief.
Cyclizine is an antimetic to stop vomiting and nausea.

On referring to the ward controlled drug book record 18/6/99 - 4/7/01 (IP/CDRD/48) , page 41 can see that I have signed for the fact that I have given Mrs GREGORY 20mgs Diamorphine at 1705 hrs on 21.11.99 and it was witnessed by someone, although I cannot recognise the signature.

These entries also correspond to an as required prescription sheet (page 184) that shows Dr BARTON prescribed 20-80mg of diamorphine SC in 24 hrs on 18.11.99. I have signed the administration record as having administered one dose at 1705 hrs on 21.11.99.

The prescription is written so as the dose is in a range in this case 20mg to 80mgs.

The dose can therefore be administered within this range. The actual dose given was a decision

RESTRICTED

taken by the nursing staff. In this case Mrs GREGORY pain was obviously being controlled by 20mgs diamorphine (the previous dose) so there was no need to increase the dose.

The entry following mine on page 240 of the record summary of significant events is undated. It should be dated 22.11.99 as the corresponding entry on page 70 of the clinical notes is after an entry dated 22.11.99.

Dr REID conducted his ward round with Dr BARTON , Sister HAMBLIN (if they were available) and the trained nursing staff. He would visit every patient, a discussion would take place regarding the care, treatment, problems etc of the patient between all present. Dr REID would record, himself, in the clinical notes his finds, recommendations and any other relevant items, he may also of examined the patient if appropriate. Dr REID's ward rounds would last all afternoon, ie, about 3 to 4 hours.

Dr BARTON conducted ward rounds Monday to Friday at about 8am (0800), she would conduct them with the senior nurse on duty. She would walk around and speak to all the patients. The nurse in charge would inform her of any problems, if the problem was brought to her attention she would deal with them, if there were no problems Dr BARTON would still walk around and visit each patient even if it was only to say a courteous good morning. The length of her ward rounds would vary, depending on the amount of problems. Her ward round would end by the start of her surgery hours and when be an hour at most. The majority of time approximately half an hour.

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Form MG11(T)

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

Statement of: SHAW, FREDA VAUGHAN

Age if under 18: O.18 (if over 18 insert 'over 18') Occupation: STAFF NURSE

This statement (consisting of 9 page(s) each signed by me) is true to the best of my knowledge and belief and I make it knowing that, if it is tendered in evidence, I shall be liable to prosecution if I have wilfully stated anything which I know to be false or do not believe to be true.

Signed: F SHAW Date: 11/07/2005

I am Freda Vaughan SHAW and I reside at an address known to Hampshire Police. I am a registered general nurse and my nursing and midwifery council number is Code A

I first qualified as a registered nurse for mentally handicapped in 1975 at Lennox Castle Hospital, Lennox Town near Glasgow.

In 1977 I completed an 18 month post registration course in order to qualify as a registered general nurse at Argyle and Bute College of Nursing and Midwifery in Greenock.

I worked for a further year at Broadfield Hospital Port Glasgow, completing that in July 1978.

I left the nursing profession in that year and worked in a variety of other positions.

In March 1992 I began work as a D Grade Staff Nurse at the Redcliffe Annexe which formed part of the Gosport War Memorial Hospital.

In 1994 I qualified as an E Grade Staff nursing which is my current grade.

Around 1995 Redclyffe Annexe was closed and all the patients were moved to Dryad Ward. I moved to Dryad Ward at this time. Both Redclyffe Annexe and Dryad Ward were for patients that required continuing care, palliative care, rehabilitation or for the terminally ill.

I have remained as a Grade E Staff Nurse on Dryad Ward ever since, until my moved to

RESTRICTED

Daedalus Ward in Sept 1998. As an E Grade Staff Nurse my role responsibilities are to supervise health care support workers and junior staff and to take charge of the ward in the absence of more senior staff. I am also responsible for the training of student nurses who are on placement at the ward.

Dryad Ward has 20 beds and the patients are primarily elderly over the age of 65 years. The majority of these are full dependent on nursing care and are usually in the ward for a 4 to 6 week period.

I have received on the job training in the use of syringe drivers . I believe I first used these in or around 1992. I have also attended study days in connection with the manufacturers requirements relating to their use.

A syringe driver is a small battery operated motorised syringe pump which has been designed to deliver a constant dosage of medicine over a set period of time. It is primarily used for continuous pain relief to patients. It can also be used to prevent nausea in patients who are very sick.

The only person who can authorise the use of drugs administered through a syringe driver is a doctor. In the early years it was policy to allow up to three different drugs to be administered via the syringe driver in one dosage over a set period. That policy has since changed.

My understanding of the terms the named nurse is that this is the person who is responsible for the nursing care of the patient. The nurses were usually allocated a four bedded bay and split into teams A and B. These were responsible for putting care plans in respect of those patients in place and keeping them up to date. The named nurse would be the person whom the patients family could speak to if that nurse was actually on duty at the time. If there were not then another member of staff would speak to them.

The time and date of all entries in the notes would usually be completed at the time, if the patient was seriously ill, but in other cases it would be completed when there was time to do so,

RESTRICTED

but in any case at the end of the tour of duty.

My tour of duty has always been from 0730 hrs to 1330 hrs (days) and 1415 hrs to 2030 hrs (lates).

I have been asked to detail my involvement in the care and treatment of Sheila GREGORY who was a patient on Dryad Ward at Gosport War Memorial Hospital and who died on 22.11.99.

At that time I was an E Grade staff nurse and my roles and responsibilities were as previously stated. My supervisor at that time was Sister Gill HAMBLIN . From memory and referral to entries made in Sheila GREGORY's medical records (identification reference BJC/21), I can state the following:

On page 237 I have recorded.

13.9.99 Seen by Dr REID on round - continue - inhalers changed to nebulisers.
I have then signed the entry.

I entry relates to a ward round that Dr REID conducted on 13.9.99 and is recorded in the clinical notes on page 67 and 68 written by Dr REID. Continue, means to continue with the care as before of Mrs GREGORY the only change being to commence a nebuliser instead of an inhaler. That would have been a change in the drug regime and the way that they were taken. Prior to 13.9.99 Mrs GREGORY was using an Atrovent Inhaler and a Becloforte Inhaler (Page 159). This was change to Iprtropium nebuliser and Budesonide nebuliser. I am unable to say why these drugs were prescribed. An inhaler requires you to breath in the medicine in a particular manner, to be able to do this the patient has to be able to understand instructions, also the patients requires to be able to breath quite deeply. A nebuliser is given via a mask and the drug to vaporised by a machine allowing the patient to breath naturally.

My next entry read:

RESTRICTED

20.9.99 seen by Dr REID for FBC-U&ES manç ? rehab
I have then signed this entry.

This again relates to a ward round by Dr REID on 20.9.99 and corresponds to his clinical note on page 68. Dr REID has requested, FBC-U&ES, full blood count and urea and electrolytes in the morning. I have no idea why Dr REID asked for the blood count for Mrs GREGORY, they can be used to monitor or indicator all manner of things, ie, infections, illness or organ impairment.

On 8th October 1999 page 238 I have recorded:

8.10.99 Continues to feel nauseas at times, small amount of diet taken, remains in bed of own choice.
I have then signed this entry.

Nauseaus - means to feel sick. Mrs GREGORY would have been encouraged by the nursing staff to mobilise, although she remained in bed of her own choice.

On 18th October 1999 page 238 I have recorded:

18.10.99 seen by Dr REID to discuss N/H with family.

I have again signed this entry. This entry corresponds with Dr REID's clinical note on 18.10.99, page 69.

This entry relates to the fact that Dr REID at that time thought that a nursing home placement would be suitable and that the nursing staff should discuss this with the family. When this would have been done the patient would have been referred to social services. At that time the plan was for Mrs GREGORY to be discharged to a nursing home.

On 20th October 1999 I have recorded (page 238):

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20.10.99 Spoke to Code A (N.O.K) re RH/NH, she is happy to discuss with social worker, can be contacted at night or weekends.
I have then signed this entry.

I social worker/social services would have to get involved in Mrs GREGORY placement as they would be aware of the availability of the homes, they would also be of help in the financial aspect of the care.

On 19th November 1999 I have given Mrs GREGORY a 40mgs dose of Frusemide at 1530 hrs intramuscularly. This prescription had been verbally prescribed by Dr BARTON , written out by Sister HAMBLIN. Dr BARTON had subsequently signed the prescription.

From looking at an entry on page 239 dated 19.11.99 I presume that the frusemide was prescribed for shortness of breath but this entry is written by Sister HAMBLIN.

On 22.11.99 I have recorded:

1720 Died peacefully
Property slip No.82060

I have signed this entry then continued.

No carotid pulse
No radial pulse
No heart beat when listening with stethoscope
No visible respiration
No inspiratory sounds of breathing when using stethoscope
No pupil reaction to light
Verified by S/N F SHAW & Sis HAMBLIN

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Both Sister HAMBLIN and I have signed this entry.

This entry corresponds with an entry that I made in the clinical notes page 76 and is written under an entry made by Dr REID dated 22.11.99.

1720 Died peacefully
Verified by
S/N F SHAW Sis G HAMBLIN
Both Sister HAMBLIN and myself have signed the entry.

No carotid artery pulse
No radial pulse
No heart beat when listening with stethoscope
No visible respiration
No inspiratory sounds of breathing when using stethoscope
No pupil reaction to light

Both entries are the same and verify the death of Mrs GREGORY. All the tests mentioned are set policy used to verify death.

It would be normal for the nursing staff to verify death if it was expected and the doctor had written words to the effect of 'I am happy for nursing staff to confirm death'.

This was normal practice during periods when there was no medical cover for the ward and the hospital. Medical cover was only available during Dr BARTON's or the consultants ward rounds or during surgery hours when you could phone Dr BARTON's practise for her or the duty doctor. They would either advise on the phone or come to the ward.

Dr REID would conduct ward rounds either weekly or every fortnight. He would conduct them with Dr BARTON and the senior nursing staff on duty. He would visit every patient discuss there care and treatment, any problems with those present, examine the patients, notes,

RESTRICTED

prescription charts, the patient and then treat them if necessary, ie, prescribe drugs or other treatment.

He would also make an entry in the clinical notes . His round would last at least a couple of hours but would vary every week.

Dr BARTON would conduct her ward rounds each morning. She would walk around, say good morning to all the patients. Any problems for any patient would be highlighted by the nursing staff to Dr BARTON who would then deal with the problem. Dr BARTON got in between 7.45am (0745) and 8am (0800) and was gone for her morning surgery. She could be in for only five minutes if there were no problems brought to her attention. She also did a ward round on Daedalus Ward at that time.

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Form MG11(T)

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

Statement of: DORRINGTON, IRENE MARGARET

Age if under 18: (if over 18 insert 'over 18') Occupation: RETIRED

This statement (consisting of 4 page(s) each signed by me) is true to the best of my knowledge and belief and I make it knowing that, if it is tendered in evidence, I shall be liable to prosecution if I have wilfully stated anything which I know to be false or do not believe to be true.

Signed: I M DORRINGTON Date: 20/10/2005

I am Irene Margaret DORRINGTON and I live at an address known to the Police.

I retired from the NHS in 1999, after 38 years nursing experience.

I retired as a Staff Nurse at Gosport War Memorial Hospital ; I cannot recall my RCN number.

In 1997 I was a Staff Nurse working night duty only on Dryad Ward at the Gosport War Memorial Hospital.

My responsibilities were in the main "patient care" and I was in charge of a team of two or three Auxiliary nurses. Our task on nights were to care for the patients, give medication, make up care plans and hand over to the day shift. My supervisor at that time was I believe to be Fiona WALKER

I don't believe I received any training in the use of I/V drugs. I may have received hand outs.

I have never heard the term the Wessex protocols.

I attended a day course at GWMH in the use and setting up of syringe drivers. I recall I was nervous regarding their use and along with others I requested more training.

Usually, by the time we came on to nights the syringe drivers for patients had already been set up for us by the day team.

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The title named nurse is something used on days, but not on nights. This was the nurse who was responsible for a particular patient and whose name was usually on a board in the nurse's station.

In relation to the time and date of all entries, I would complete these in the notes when I had finished all of my jobs, however if the patient was really poorly I would write in the notes at the time.

As I have said I only worked a night duty. I worked 20 hours per week which consisted of two nights. My hours were from 1930 until 0730 the following day. This was a flexible arrangement.

I have been asked to detail my involvement in the care and treatment of Sheila Gregory b. 12/07/1908.

I do not recollect this patient or the care administered. From referring to the medical notes (exhibit ref BJC/21) I can confirm that I have written the following entry on page 238.

1/10/99 Found on floor twice in the night 1.00 & 2.25 small tear on outer aspect of L leg just below knee, accident form completed. I. DORRINGTON

This entry is self explanatory however it is worth noting that this patient's bed had cot sides fitted to either side of the bed, which meant that to get out of bed, she would only be able to get out at the bottom of the bed.

I note that the entry dated 1/10/99 on page 205 of the nursing notes i.e. the care plan refers to the treatment of a tear to the left leg of this patient. This treatment has commenced as a result of my handover to the day nursing staff.

I can confirm that on page 201 of the notes (The nursing care plan for the night nursing staff) I

RESTRICTED

have written the following entries;

30/9/99 - Restless night. Sedation given without affect.

To clarify this entry I would have administered one 10mg Temazepam tablet to the patient to assist her to sleep. In this case the dose of Temazepam did not have affect on the patient.

Found on floor twice although observations kept up.

To clarify this entry the patient has obviously been restless. One Temazepam 10mg tablet would have been given at 10pm (2200).

By 1am (0100) the following morning 1/10/99 the patient was found to be on the floor and again at 0225. On this occasion the patient had sustained a tear to her leg as I have recorded.

6/10/99 Still awake and restless at 0200 Thioridazine 10mg given with good effect.

To clarify Thioridazine was administered to relieve the patient's anxiety which was achieved.

My next entry on page 201 reads as follows;

7/10/99 Temazepam 10mg & Thioridazine given as prescribed slept soundly all night.

To clarify this entry Temazepam and Thioridazine were administered as they had been prescribed by Dr BARTON on 7/10/99.

Again on page 201 of the notes I have written the date 17/10/99 and signed a blank entry. I interpret this to mean that there had been no significant change to the patient and that she was sleeping through the night at that time.

Page 202 of the medical notes is a continuation sheet of the night care plan. I can confirm that I have written the following entries;

22/10/99 -C/o = (Complains Of) *indigestion - Gaviscon given with good effect.*

31/10/99 - (no entry has been made other than the date)

02/11/99 - (no entry has been made other than the date)

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12/11/99 - (no entry has been made other than date)
These entries indicate that there has been no significant change to the patient.

15/11/99 - Slept well- Self explanatory.
16/11/99 - Appears to be unwell. Settled down well but this morning (i.e.17/11/99) *Not herself Paracetamol given for discomfort.*

I cannot recollect exactly what medical problem this patient had, but I would have drawn it to the attention, of the day nursing staff at handover time.

I can confirm that I have written the following entry on page 204;

17/11/99 Settled to sleep- good night. Still C/o (complains of) *pain in neck area. Paracetamol given, still pale.*
To clarify this entry the patient has complained of a pain to her neck. I have given a paracetamol tablet. However I have noted that she was pale in colour.

Page 210 of the medical records is the nursing care plan for the observations of the patient's bowels.
I have written the following entries;

26/9/99 0100 small faecal incontinence this is self explanatory.
30/9/99 BO = (Bowels Open i.e. normal function)
30/9/99 Small Bo This is a small movement of the bowels.

I can confirm that I have made a number of entries on page 154 of the medical records. This is the prescription sheet recording drugs administered to Sheila GREGORY.
I have administered a 3.75 mg tablet of Zoplicone (a sleeping tablet)
24/9/99 at 2245
25/9/99 at 2200
29/9/99 at 2225

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I can confirm that I administered 2 Senna tablets on the 24/10/99 and 25/10/99 and again on the 29/10/99 and 30/10/99. Sennacot is an aperients this helps a patient's bowel movement.

On the 20/10/99, 1/11/99, 17/11/99 and 18/11/99 I administered 2mg Loperamide to the patient. She was prescribed this drug to be given 4 times a day. Loperamide is an anti diarrhoeal medication.

I administered paracetamol to the patient as recorded on pages 145 and 147 of the medical records.

I can confirm that I administered 10mg of Thioridazine at 2200hrs on 7/10/99. Thioridazine is a relaxant which was used to relieve any anxiety.

Temazepam was administered by me at 2200 on 7/10/99, 17/10/99, 22/10/99, 29/10/99, 30/10/99, 31/10/99, 2/11/99 as recorded on pages 149 and 151 of the medical records.

I had no further dealings with this patient.

RESTRICTED

Form MG11(T)

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

Statement of: EVANS, CHRISTINE ELIZABETH

Age if under 18: O.21 (if over 18 insert 'over 18') Occupation: RGN STAFF NURSE

This statement (consisting of 4 page(s) each signed by me) is true to the best of my knowledge and belief and I make it knowing that, if it is tendered in evidence, I shall be liable to prosecution if I have wilfully stated anything which I know to be false or do not believe to be true.

Signed: C Evans Date: 16/06/2005

I qualified as an enrolled nurse in January 1972 working at Tamworth General Hospital, Staffordshire. My nursing and midwifery number is Code A In 1983 I moved to Portsmouth and worked at the Gosport War Memorial Hospital initially I worked part time day duty wherever the hospital was short either on the male or the female wards. Subsequently I took a full time position working days on Redcliffe Annexe, which was a street away from the main hospital. Redcliffe was a geriatric ward.

In 1989 I left Gosport War Memorial Hospital and did a student registered nursing course at the Queen Alexandra Hospital, Portsmouth. In February 1990 I qualified as a RGN Registered General Nurse.

I then went back to Redcliffe Annexe but this time worked as an E Grade Staff Nurse, from there I worked at St Christopher's Hospital in Fareham working on Beech Ward, a geriatric ward working days full time.

In about 1999 I transferred back to Gosport War Memorial Hospital as a relief staff nurse E grade for Daedalus and Dryad Wards working nights full time three times a week. The hours I believe were from 8.30 p.m. (2030) to 7.30 a.m. (0730) all hospitals have different night duty hours. On the ward during a night would be two trained nurses i.e. RGN or an Enrolled Nurse ideally and two support care nurses, i.e. untrained.

During the night I would be classed as team leader and would be responsible for the overall running of the ward, including the care and treatment of the patients, safety, the untrained

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nurses, basically everything.

Although there would be a senior nurse on duty within the hospital who was the night sister, who at that time was Fiona WALKER . She was based on another ward, Sultan Ward and was available if I had any major problems, required advice or assistance. There would also be a Doctor on call who you could ask for advice from via the phone.

I have had no training in the administration of intravenous drugs and have never administered an IV drug. This was not part of my role. I have attended a study day regarding IV drugs but that is all.

I have never heard of the term Wessex Protocols.

I have been trained in the use of syringe drivers and I have attended a study day regarding there use. I am unsure now where the lecture was or when it was. In 1999 syringe drivers were being used on both Daedalus and Dryad Wards. They were being used appropriately for pain control. I never had any concerns with regard to there use.

In September 2001 my husband died so in March 2002 I moved back to Tamworth and took a break from nursing for approximately 2 years.

I have been asked to detail my involvement in the care and treatment of Sheila GREGORY . I have no personal recollection of Mrs GREGORY but from referral to her medical records (BJC/21) page 238 I can say that I made the following entry

24/9/99 Found on floor next to bed @ 00.45
No apparent injuries please observe
for bruising. Accident form completed
Cot sides (R) & (L) side of bed now
in situ.

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I have ten signed the entry C Evans

I would have been working nights on Dryad Ward with other members of staff. Mrs GREGORY was found on the floor at 0045 hrs. I cannot say how Mrs GREGORY ended up on the floor as no one saw her. She may have got there on her own accorded fallen out of bed or got out of bed and then fallen. I examined Mrs GREGORY and found that she had no injuries eg. broken bones or lacerations. I requested that the nursing staff observed for bruising, that would indicate whether she fell out of bed and where any injury might be. If there was any accident or a probable accident to any patient or any one on the ward then an accident form would be completed detailing the incident, I therefore completed an accident form. I also ensured that both cot sides right and left side of the bed were in place to prevent Mrs GREGORY from falling, or rolling out. As I have written now it appears to me that the cot sides were not in place previously.

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Form MG11(T)

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

Statement of: Code A

Age if under 18: OVER 18 (if over 18 insert 'over 18') Occupation: DETECTIVE CONSTABLE Code A

This statement (consisting of 1 page(s) each signed by me) is true to the best of my knowledge and belief and I make it knowing that, if it is tendered in evidence, I shall be liable to prosecution if I have wilfully stated anything which I know to be false or do not believe to be true.

Signed: C S YATES Date: 07/09/2005

I am Code A Detective Constable Code A of the Hampshire Constabulary presently attached to the Major Crime Department.

In addition to my previous statement regarding the interview of Doctor Jane BARTON on 25th August 2005, I wish to add the following. I have caused the tape of the interview bearing the identification reference CSY/JAB/9 to be fully transcribed. The transcript of this interview is now available with an identification reference of CSY/JAB/9A.

Signed: Code A

Signature Witnessed by: