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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 in Mrs Gregory's records in this regard reads as follows:- And my note

Code A

"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 snuff box - 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.

Agreed and handed to Dr. Yates
25-2-05

Code A