SHEILA GREGORY

CASE SUMMARY

BACKGROUND

The Gosport War Memorial Hospital (GWMH) is a 113 bed community hospital which is managed by the Fareham and Gosport Primary Care Trust (PCT). It was part of Portsmouth Health Care (NHS) Trust from April 1994 until April 2002, when the services were transferred to the local PCT. It is operated on a day-to-day basis by nursing and support staff, employed by the PCT. Clinical expertise is provided by way of visiting general practitioners and clinical assistants, consultant cover is provided in the same way.

Elderly patients are usually admitted to GWMH through referrals from local hospitals or general practitioners for palliative, rehabilitative or respite care.

Doctor Jane BARTON is a registered Medical Practitioner who, in 1988, took up a part-time position at GWMH as Clinical Assistant in Elderly Medicine. She retired from that position in 2000.

POLICE INVESTIGATIONS

Operation ROCHESTER is an investigation by Hampshire Police Major Crime Department into the deaths of a large number of elderly patients at GWMH. It was alleged that elderly patients who were admitted to the GWMH from as far back as 1989 for rehabilitative or respite care, were inappropriately administered Diamorphine by use of syringe drivers, resulting in their deaths.

Most of the allegations involve a particular General Practitioner, Doctor Jane BARTON. Death certificates of patients who died at the GWMH between 1995 and 2000 total 954, of which 456 were certified by Doctor Jane BARTON.

This matter has been investigated by Hampshire Police on three separate occasions.

First Police Investigation

Hampshire Police investigations commenced in 1998 following the death of Gladys RICHARDS, aged 91 years.

Mrs RICHARDS died at the GWMH on Friday 21st August 1998 whilst recovering from a surgical operation carried out at the nearby Royal Haslar Hospital to address a broken neck of femur on her right side (hip replacement).

Following the death of Mrs RICHARDS, two of her daughters, Mrs MACKENZIE and Mrs LACK complained to the Hampshire Police about the treatment that had been given to their mother at the GWMH. Mrs MACKENZIE contacted Gosport police on 27th September, 1998 and alleged that her mother had been unlawfully killed.

Officers from Gosport C.I.D. carried out an investigation and in due course, a file was submitted to the Crown Prosecution Service.

In March 1999 the Reviewing CPS Lawyer gave the opinion that on the evidence available, he did not consider a criminal prosecution was justified.

On hearing of this decision, Mrs MACKENZIE expressed her dissatisfaction with the quality of the police investigation and made a formal complaint against the officers involved.

The complaint made by Mrs MACKENZIE was upheld and a review of the police investigation was carried out.

Second Police Investigation

A team of detectives from the Major Crime Department (Eastern) commenced the re-investigation into the death of Gladys RICHARDS on Monday 17th April, 2000.

Professor Brian LIVESLEY, who is an elected member of the Academy of Experts, provided expert medical opinion. Professor LIVESLEY provided a report dated 9th November 2000 of his findings in the case of Gladys RICHARDS. Professor LIVESLEY made the following conclusions:

- "Doctor Jane BARTON prescribed the drugs Diamorphine, Haloperidol, Midazolam and Hyoscine for Mrs Gladys RICHARDS in a manner as to cause her death."

- "Mr Philip James BEED, Ms Margaret COUCHMAN and Ms Christine JOICE were also knowingly responsible for the administration of these drugs."

- "As a result of being given these drugs, Mrs RICHARDS was unlawfully killed."

Professor LIVESLEY provided a second report dated 10th July, 2001 during which he added:

- "It is my opinion that as a result of being given these drugs, Mrs RICHARDS death occurred earlier than it would have done from natural causes."

As a result of Professor LIVESLEY's report dated 9th November 2000, a meeting took place on 19th June, 2001 between senior police officers, the CPS caseworker Mr. Paul CLOSE, Treasury Counsel and Professor LIVESLEY. During that meeting, Treasury Counsel came to the view that Professor LIVESLEY's report on the medical aspects of the case, and his assertions that Mrs RICHARDS had been unlawfully killed were flawed in respect of his analysis of the law. He was not entirely clear of the legal ingredients of gross negligence/manslaughter.

In August, 2001 the Crown Prosecution Service advised that their was insufficient evidence to provide a realistic prospect of a conviction against any person.

Local media coverage of the case of Mrs Gladys RICHARDS resulted in other families raising concerns about the circumstances of their relatives' deaths at the GWMH. As a result of this four more cases were randomly selected for review.

Expert opinions were sought of a further two medical professors. These were Professors FORD and MUNDY who were each provided with copies of the medical records of the four cases in addition to the medical records of Gladys RICHARDS.

The reports from Professor FORD and Professor MUNDY were reviewed the Police and a decision was taken not to forward them to the CPS as they were all of a similar nature to the RICHARDS case and would therefore attract a similar reply. A decision was then made by the Police that there would be no further police investigations at that time.

Copies of the expert witness reports of Professor FORD and Professor MUNDY were forwarded to the General Medical Council, the Nursing and Midwifery Council and the Commission for Health Improvement for appropriate action.

Intervening Developments between Second and Third Investigations

On 22nd October, 2001 the Commission for Health Improvement (CHI) launched an investigation into the management, provision and quality of health care for which Portsmouth Health Care (NHS) Trust was responsible in GWMH.

A report of the findings of the CHI investigation was published in May 2002. The report concluded that a number of factors (detailed in the report) contributed to a failure of the Trust systems to ensure good quality patient care. However, the Trust now has adequate policies and guidelines in place that are being adhered to, governing the prescription and administration of pain relieving medicines to older patients.

Following the CHI Report, the Chief Medical Officer, Sir Liam DONALDSON, commissioned Professor Richard BAKER to conduct a statistical analysis of the mortality rates at GWMH, including an audit/review of the use of opiate drugs.

On Monday 16th September, 2002 staff at GWMH were assembled in order to be informed of the intended audit at the hospital by Professor BAKER. Immediately after the meeting concluded, nurse Anita TUBBRITT, who had been employed at GWMH since the late 1980s, handed over to the hospital management a bundle of documents. These documents were copies of memos, letters and minutes all relating to the concerns of nursing staff which were raised at a series of meetings held in 1991 and early 1992 about the increased mortality rate of elderly patients at the hospital, the sudden introduction of syringe drivers and their use by untrained staff and the use of Diamorphine unnecessarily or without consideration of the sliding scale of analgesia (Wessex Protocol). Concerns raised by nursing staff in relation to the prescribed Diamorphine involved Doctor Jane BARTON.

As a result of the disclosure of the 1991 documents the existence of the documents was reported to the police and a meeting of senior police and NHS staff was subsequently held on 19th September, 2002 at Hampshire Police Support Headquarters. The following decisions were made at that meeting:

Further police enquiries were necessary in light of the new information and an enquiry team would be assembled and based at Hulse Road, Southampton. The enquiry team would:

- Examine the new documentation and investigate the events of 1991;
- Review existing evidence and new material in order to identify any additional viable

lines of enquiry;
- Submit the new material to the experts and subsequently to CPS;
- Examine individual and corporate liability.

It was decided that a press release was necessary, which would include a free phone telephone number for concerned relatives to contact police.

Third Police Investigation

On 23rd September, 2002 Hampshire Major Crime Investigation Team commenced enquiries. Initially, relatives of 62 elderly patients contacted police with regards to the deaths of the patients at GWMH. A number of these relatives are part of a family group being represented by a firm of solicitors, namely ALEXANDER HARRIS of Manchester. Others contacted police through an NHS direct free phone number or directly, as a result of publicity.

During his review of patients medical records at GWMH, Professor Richard BAKER identified 16 cases which were of concern to him in respect of pain management. These 16 cases together with 12 other cases which transpired during the Police investigation have brought the total number of cases reviewed by the Police to 90.

The third police investigation has been conducted in stages, as follows:

Stage One

Enquiries into the documents and events of 1991. (Now completed)

In summary, the events of 1991 were as follows:

- A number of night-nursing staff at GWMH had concerns as earlier stated and held a private meeting to discuss the issues. They were conscious of an on-going case within the NHS of GRAHAM PINK, a Charge Nurse working in the care of elderly patients in Stockport, who was dismissed for "whistle blowing".

- It was decided that three of the nurses would approach the hospital management and raise their concerns. The nurses raised their concerns with the Patient Care Manager, Isabel EVANS.

- A series of meetings took place between management, medical and nursing staff.

- A final meeting took place in which the nursing staff were informed by both the hospital management and medical staff, that the problems raised were due to a lack of understanding by nursing staff concerning the use of Diamorphine. In addition, there was also a training issue in relation to syringe drivers.

- Although the nursing staff were not entirely happy with the outcome of the meetings, they felt that they had done everything they could in raising the issues, but in light of the PINK case, felt there was no more they could do, apart from retaining the documentation.

Stage Two

Obtaining further expert medical opinions/screening process.

A team of medical experts (key clinical team) was appointed to review all 90 cases. This team was headed by Professor Robert FORREST a specialist in Toxicology, the other members being experts in the fields of General Medicine, Palliative Care, Geriatrics and Nursing.

Their terms of reference were to examine the patient notes independently and to assess the quality of care provided to each patient. The Clinical Team was not confined to looking at the specific issue of syringe drivers or Diamorphine but to look at the overall care in general. The purpose of the reviews being to screen the cases and identify where appropriate, areas for concern that may warrant further investigation by the Police. At the same time they could identify cases where there were no concerns and the treatment that had been provided was appropriate in the circumstances.

A matrix was devised by them to allow each patients care to be scored and assessed. Using this system patient care was categorized and cases were placed in one of the three below categories:

1. Optimal care
2. Sub – Optimal care
3. Negligent care

The team was provided with approximately 20 cases for review every three months. At the conclusion of each review stage the experts attended a Conference where they could collectively discuss their findings and present them to the investigative team.

Each expert was briefed regarding the need to keep their notations and findings for possible disclosure to interested parties at a later stage in line with CPIA 1996. They were not required however, to produce evidential expert reports for reliance at Court on each individual.

The key clinical team reviewed a total of 90 cases and identified 13 cases that fall into category 3, a similar number in category 1 and the remainder being category 2.

All cases in categories 1 and 2 were quality assured by a medical/legal expert, Matthew LOHN, before the decision was made that there was no basis for further criminal investigation.

Cases in category 2 have been referred to the General Medical Council and the Nursing and Midwifery Council for their respective considerations.

Category 3 cases are being further investigated in stage three of the investigation. These cases were placed in further categories in relation as to the cause of death as follows:-

A natural
B unclear
C unexplained by illness

Stage Three

Obtaining medical expert evidence and submission of case file(s) to CPS

Two further medical experts have been appointed to review all 13 of the cases in category 3 with a view to determine causation and, if required, give evidence in court. These experts are Dr Andrew WILCOCK and Dr Robert BLACK and have been required to work independently of each other.

In respect of each case these experts are reviewing medical records, statements from medical and nursing staff, statements from family members of deceased and transcripts of suspect interviews. They are also being provided with any reports or other documents, such as the CHI report and hospital protocols, specifically requested by them.

The experts were also provided with 'Guidance for Medical Experts' document which assists them to understand the terms Criminal Gross Negligence and Unlawful Act within the context of Homicide.

Below are the 10 category 3 cases which Dr's WILCOCK and BLACK are reporting on but not necessarily in this order.

1. Elsie DEVINE
2. Elsie LAVENDER
3. Arthur CUNNINGHAM
4. Sheila GREGORY
5. Robert WILSON
6. Enid SPURGEN
7. Leslie PITTOCK
8. Helena SERVICE
9. Ruby LAKE
10. Geoffrey PACKMAN

Files of evidence in respect of each case are being submitted piecemeal to CPS for their consideration in the following format.

Confidential information
ROCHESTER case summary
Specific case summary
Expert report Dr WILCOCK
Expert report Dr BLACK
Witness list
Family member witness statements
Medical and Nursing witness statements
Police officer witness statements
Transcript suspect interviews

CASE OF SHEILA GREGORY

Background/family observations

Sheila GREGORY was born on 12th July 1908. 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. Apparently Mrs GREGORY became ill after childbirth and could not have anymore children after that. 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 Anns Hill Cemetery.

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 Code A 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.

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NATURAL

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 Code A Code A and DC Code A

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

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 **Code A**

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.

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.

Wendy HARRISON (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.

Nicolas HAJIANTONIS (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.

Prem Swaroop MISRA (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.

Simon MACKIE (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.

Dominic TOLLEY (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.

Penelope GORDON (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.

Debra BARKER (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.

Code A (Detective Constable) Re interview Dr BARTON 25th August 2005.

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

HAMPSHIRE CONSTABULARY

C.51 1/99

Identification Ref. No. DB 2005

Court Exhibit No.

R - v -

Description

A CERTIFIED COPY OF A DEATH CERTIFICATE (GREGORY

Time/Date Seized/Produced

19TH MAY 2005

Where Seized/Produced

Office for National Statistics.

Seized/Produced by

D. BURGESS

Signed

Incident/Crime No. Operation Rochester

Major Incident Item No. X 6 1 2

Laboratory Ref:

PLEASE ATTACH WITH TAPE

GLOUCESTERSHIRE CONSTABULARY

Station.

J1 No. Item No.

O.I.C.

Identification Ref No.

Court Exhibit No. DB 2005

R-v-

Description

A CERTIFIED COPY OF A DEATH CERTIFICATE

Time / Date Seized / Produced

19TH MAY 2005

Where seized / Produced

OFFICE FOR NATIONAL STATISTICS

Seized / Produced By

DAVID BURGESS

Signed Code A

Incident Crime No. Operation Rochester

Major incident item No.

Laboratory Ref

P27B (Rev 2/02)

Code A

Note (1) Births and Deaths.

This certificate is issued in pursuance of the Births and Deaths Registration Act 1953. Section 34 provides that any certified copy of an entry purporting to be sealed or stamped with the seal of the General Register Office shall be received as evidence of the birth or death to which it relates without any further or other proof of the entry, and no certified copy purporting to have been given in the said Office shall be of any force or effect unless it is sealed or stamped as aforesaid.

Note (2) Births.

A name given to a child (whether in baptism or otherwise) before the expiration of twelve months from the date of registration of its birth, may be inserted in Space 17 of the entry in the birth register under the procedure provided by Section13 of the Births and Deaths Registration Act 1953. If the parents or guardians wish to avail themselves of this facility at any time, they must deliver a certificate of baptism or of naming to the registrar or superintendent registrar having the custody of the register in which the birth was registered. This certificate must be in the prescribed form and can be obtained on application to any registrar.

Copy JB/PS/2

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

Code A

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 Code A 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 PC Code A

25-2-03

Code A