RESTRICTED

Form MG11(T)

WITNESS STATEMENT

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

Statement of: GRUNSTEIN, JOHN ALBERT HENRY

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

This statement (consisting of 6 page(s) each signed by me) is true to the best of my knowledge and belief and I make it knowing that, if it is tendered in evidence, I shall be liable to prosecution if I have wilfully stated anything which I know to be false or do not believe to be true.

Signed: J GRUNSTEIN Date: 04/11/2005

I am Doctor John Albert Henry GRUNSTEIN and I am a retired medical Consultant previously employed by Portsmouth Health District and successor organizations. I retired in 2000.

My qualifications and CV are as follows:

1. Date of Birth: Code A
2. Place of Birth: London
3. Medical School: London Hospital, Whitechapel 1968-1963
4. Registrable Medical Qualifications:
    a. 1963 MRCS, LRCP
    b. 1963 MB, BS Lond.
5. Higher Registrable Medical Qualifications:
    a. 1968 MRCP Lond.
    b. FRCP Lond.
6. Relevant Appointments:
    a. 1969-70 Senior Registrar Geriatric Medicine Guy's Hospital
    b. 1971 Appointed Consultant Physician in Geriatric Medicine to the Portsmouth Health District and successor organizations.
    c. 2000 Retired.
7. Since retirement I have continued to work as a part time locum in various capacities.
8. *Responsibilities in Gosport:*
    a. Shortly after I was appointed I initiated an outpatient service in Gosport.

b. I shared responsibility for the continuing care wards in Gosport. Initially these were in the Northcote and Redcliffe annexes of Gosport War Memorial Hospital.

c. In 1992, I believe, I gave up all responsibilities in Gosport.

Dr. Jane BARTON applied for the post of Clinical Assistant in Geriatrics at the Gosport War Memorial Hospital, Hants. On 17th March 1988. I also believe that she was the only applicant for the post. I have seen her application sent to me recently from the Queen Alexandra Hospital, Cosham, Hants . This occurred following a request to the Elderly Medicine Department to ascertain if they could unearth any relevant documentation. I cannot recall whether Dr BARTON was formally interviewed for the post, to which she was appointed. At the time of her application and subsequent appointment, I was a Consultant with a clinic and shared responsibility for long stay (as they were then termed) beds in the Gosport area.

Dr. BARTON was an experienced doctor with her own general practice in Gosport. I remember her as being very good. She enjoyed the work and her heart seemed to be in it. (Not always true of those employed in similar capacities). She had a liking for these very frail elderly patients. Documentation is available showing that there was initial training consisting of ten half day sessions. She probably attended ward rounds, outpatients and day hospital sessions in order to get "hands on" training, during which we would discuss the management of patients. This training period covered most aspects of elderly care but I would not describe it as "in depth".

Dr. BARTON was an experienced doctor and a Principal in General Practice. I would not treat her in the same way as a very junior colleague. I recall her as attending these sessions assiduously and showing interest in her duties.

She also attended the Clinical Assistant Training Program - Elderly. (CATPE). This was a series of lectures given in the training of most aspects of elderly medicine, including lectures in palliative care, causes of confusion (dementia), strokes, falls, incontinence, heart and lungs disease all from the point of view of elderly medical care. These covered relevant topics appertaining to the elderly who often have different diagnostic presentations and requirements compared to younger patients. She probably would also have heard about the

"analgesic ladder" which describes the incremental use of drugs to control pain and distress. The analgesics would usually (though by no means always) start with paracetamol and progress through to the opiates including diamorphine.

CATPE was given in a lecture theatre environment. Doctors also gave case presentations which were open to discussion. I am reasonably certain that in addition to attending CATPE, Dr BARTON gave presentations.

Routine Business Ward Rounds with Dr BARTON would have taken the form of reviewing new patients, assessing those with problems and some cyclical patient reviews. It would be my responsibility to offer advice on the best management of patients including investigation, diagnosis and treatment. This would include advice on drug dosages. I might also suggest the administration of alternative drugs and dosages to patients. I would expect my advice to be followed as ultimate responsibility for patient care was the consultant's. The nature of Dr BARTON's post required that she exercise a considerable degree of autonomy.

Dr. BARTON made arrangements within her own practice for cover whilst she was unavailable or off duty, though I thought it notable how assiduous she was in making herself available. I think it is fair to say that the nurses were unusually reliant on Dr BARTON. Dr. PETERS and others from her practice worked on the wards while she was unavailable. My department didn't vet the skills of these doctors. Cover was twenty four hours a day, seven days a week.

Admissions to all elderly medicine continuing care wards (long stay wards) were authorized by a consultant in elderly medicine and occasionally by a registrar acting up as a consultant locum.

During their time in hospital the patients own General Practitioner had no responsibility or supervisory rights.

During the time that I had specific responsibilities in Gosport (1971-1992). Patients

transferred to Gosport had varying combinations of illness, frailty and severe disability. They were thought to be unlikely to benefit from rehabilitation, which was not specifically available for elderly medicine in Gosport.

Occasional patients were transferred to await discharge to non NHS accommodation (Residential or Nursing Home) or home. Some patients improved and were also discharged.

The bulk of patients transferred to Gosport were considered too incapacitated to be cared for in registered nursing homes (i.e. the frailest of the frail), though over the years the political, financial and logistical reasons governing the balance between NHS and private care has shifted towards the latter. Palliative care (care of the dying) was a significant part of our work.

The survival time of new admissions was short (on average less than a month), but the average length of stay was long. (perhaps a year). I cannot recall precise figures, which anyway would depend on the definitions adopted and would fluctuate wildly.

I believe that allegations have been made concerning the quality of care given by Dr BARTON. I have never seen any of these in writing, but I have had informal occasional chats with colleagues (no more than gossip) and come across references in the media. To say that I was incredulous is to understate my position.

I considered Dr BARTON to be an outstanding, caring and compassionate Physician.